SIEBER KIEFERORTHOPÄDIE

Pat. Nr. _____

REGISTRATION FORM ***Adults***

Last Name ..... First Name .....

Date of birth ..... ☐ Male ☐ Female

Current Address ..... Postcode ..... City .....

Phone ..... Email .....

Profession / Employer .....

Your dentist ..... When was your last caries control? .....

By whom were you transferred? .....

Did you ever undergo an orthodontic treatment? ☐ No ☐ Yes

If yes, where? ..... When? .....

Insurance ..... Insurance number .....

Are you a recipient of welfare benefits? ☐ No ☐ Yes

Are you a recipient of supplementary benefits? ☐ No ☐ Yes

HEALTH CONDITION

Name and address of your physician? .....

Are you under medical treatment? ☐ No ☐ Yes

If so, why? .....

Are you taking any medications? ☐ No ☐ Yes, which? .....

Have you ever had a severe illness? ☐ No ☐ Yes, which? .....

Have you ever needed a hospital treatment? ☐ No ☐ Yes, why? .....

Have you had any injuries to the face, mouth or teeth? ☐ No ☐ Yes, which? .....

Do you or did you suffer from:

☐ Allergies ☐ Rheumatism ☐ Hepatitis B ☐ HIV, Aids ☐ Blood clotting problems ☐ Asthma

☐ Diabetes ☐ Epilepsy ☐ Heart Disease ☐ Drug compatibility ☐ Other .....

☐ Nothing applies

All information are subject to the medical confidentiality. The signer agrees that the personal data included in this form could be shared with others related to invoicing / accounting and payment system and that the relevant correspondence could be sent via email.

Date ..... Signature .....