ZAHN GESUND.
Ihre Zahnärzte an den Arcaden

Personal details:

Patient:

Last name _____

First name _____

Date of birth _____

Address _____

Phone at home _____

Phone at work _____

Insurance _____

Statutory _____

Private _____

Member (if not the same as patient):

Last name _____

First name _____

Date of birth _____

Address _____

Occupation _____

Place of work _____

Medical history:

Are you on any regular medication? _____

Do you have any allergies? _____

Do you suffer from heart disease? _____

Do you have any circulatory problems? _____

Do you have any metabolic disorders? _____

Do you have any blood disease? _____

Do you have any infectious disease? _____

Do you smoke? _____

Are you pregnant? _____

Thank you very much for your co-operation. Please let us know of any changes.
Please note that you have to give at least 24 hours notice if you wish to cancel an appointment.
Otherwise we will invoice you for the lost time. We ask for your understanding in this matter!

Date _____

Signature _____