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## Registration form with anamnesis

Dear patient,  
a warm welcome to our dental office. Please answer the following questions conscientiously to ensure a safe treatment. Your data will be handled confidentially. Our "personal data collection statement" is accessible at our office. Thank you very much for your cooperation.

### Patient

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Date of birth: \_\_\_\_\_  
Street, No: \_\_\_\_\_  
Zip code and city: \_\_\_\_\_

### Member

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Date of birth: \_\_\_\_\_

eMail: \_\_\_\_\_  
Occupation/  
Profession: \_\_\_\_\_

### Tel. number

Tel. no. private: \_\_\_\_\_  
Mobilephone: \_\_\_\_\_  
Tel. no. work: \_\_\_\_\_

### Who should receive the bill?

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Date of birth: \_\_\_\_\_  
Street, No: \_\_\_\_\_  
Zip code and city: \_\_\_\_\_

Insurance company \_\_\_\_\_

Do you have a supplementary insurance? yes ☐ no ☐

### How did you hear about us?

Acquaintance/ recommendation ☐  
Internet ☐  
Ad/ newspaper ☐  
Phone book ☐  
Practice sign ☐  
Other ☐ \_\_\_\_\_

### Are there any health risks?

If yes, which ones? \_\_\_\_\_

Do you have any allergies or intolerances?

If yes, which ones? \_\_\_\_\_

Do you suffer from heart/cardiovascular diseases? yes ☐ no ☐  
Do you have a pacemaker? yes ☐ no ☐  
Do you suffer from a coagulation disorder? yes ☐ no ☐  
Do you take bisphosphonates? yes ☐ no ☐  
Do you take any blood thinners (e.g. Marcumar, Xarelto)? yes ☐ no ☐  
Do you suffer from high blood pressure? yes ☐ no ☐  
Do you suffer from low blood pressure? yes ☐ no ☐  
Do you suffer from other infectious diseases (HIV, Hepatitis,...)? yes ☐ no ☐

If yes, which ones? \_\_\_\_\_

Are you infected with the Creutzfeldt-Jakob disease? yes ☐ no ☐  
Do you suffer from thyroid diseases? yes ☐ no ☐  
Do you take any medicine regularly? yes ☐ no ☐

If yes, which ones? \_\_\_\_\_

Do you suffer from glaucoma? yes ☐ no ☐  
Do you have diabetes? yes ☐ no ☐  
Are you pregnant? yes ☐ no ☐

If yes, which month? \_\_\_\_\_

I need a new bonus booklet from my statutory health insurance yes ☐ no ☐

I agree to report any changes of my health condition during the entire treatment period immediately. I further agree to keep all scheduled treatment appointments or to cancel them at least 24 hours prior to the scheduled appointment. I understand that appointments not cancelled in time will be billed.

To the best of my knowledge, all of the preceding answers are true and correct.

**Stuttgart,**

\_\_\_\_\_  
**Patient or legal guardian**