Laura M. Gröne, geb. Hild
Fachzahnärztin für Kieferorthopädie

Kölnstr. 54
53111 Bonn

Tel.: 0228 - 62917707
Fax: 0228 - 62917708

Patient Data Sheet

(Please Print All Information)

Family Name, First Name (Patient)	Date of Birth, Sex: m f
Street Address	Zip, City, Country
Home Phone / Cell Phone	Work Phone
E-Mail	Profession
Insurance Company Name	
Reffering Physician – Name, Address, Phone	
Family Doctor – Name, Address, Phone	

If insured person is differing from patient mentioned above please fill in:

Family Name, First Name (insured person)	Date of Birth
Street Address	Zip, City, Country

Consent of treatment of a Minor

If patient is under the age of 18, parental consent for treatment (except acute ache) of a min is required:

Date	Parent / Legal Guardian Signature

Please answer the following questions regarding your state of health as exactly as possible:

State of Health	**Please mark**		**Further Information**
Cardiovascular Diseases:			
Hypertension	Yes	No	
Hypotension	Yes	No	
Valvular Heart Disease/Defect			
Endocarditis	Yes	No	
Heart Surgery	Yes	No	
Pacemaker	Yes	No	
Infectious Diseases:			
AIDS		Yes	
Hepatitis		Yes	
Tuberculosis	Yes	No	
other:			

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Allergies / Intolerances:	**Please mark**		**Further Information**
Local Anesthetics	Yes	No	
Analgesics	Yes	No	
Antibiotics	Yes	No	
other:			

Further Diseases:

Coagulation Diseases	Yes	No	
Asthma	Yes	No	
Lung Diseases	Yes	No	
Thyroid Diseases	Yes	No	
Rheumatism	Yes	No	
Epilepsy	Yes	No	
Diabetes	Yes	No	
Nephropathy	Yes	No	
Fainting	Yes	No	
orther:			

General Data:

Smoker	Yes	No	If yes, 0-10 over 10 cigarettes/day
Regular Medication/Drugs	Yes	No	If yes, since when / Name:
X-Rays taken before	Yes	No	If yes, Date / Body Parts:
Gravidity / Pregnancy	Yes	No	If yes, what month:
Agreement for X-Rays?			

Important Information:

- All information is subject to professional medical secrecy and to the regulations on the protection of the privacy of personal data and treated strictly confidential.
  I agree to those data being saved and processed electronically.
- I engage myself to inform you immediately about all changes occurring during the period of treatment.
- I engage myself to keep agreed appointments or to chancel them at least 2 days in advance, otherwise occurring costs can be invoiced.
- I certify with my signature that I have read and understand all above printed **information**.

Date | Patient Signature and Parent / Legal Guardian Signature