

# Registration Form

Mrs. Dr. Ulrike Withelm, Hauptstr. 1, 69117 Heidelberg

Patient: \_\_\_\_\_  
Surname First name Date of Birth Health Insurance

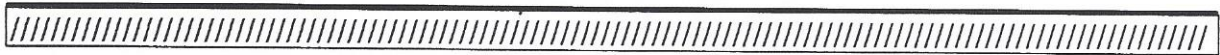
Family member insured: \_\_\_\_\_  
Surname First name Date of Birth

Address: \_\_\_\_\_  
Street Postal Code/Town Telephone

Employer: \_\_\_\_\_ Profession: \_\_\_\_\_

Are you entitled to receive the German health care allowance public servants?

Were we recommended to you by someone?



Are you in dental treatment at the moment?  Yes  No  
If yes, why? \_\_\_\_\_

Do you take any medication regular?  Yes  No  
If so, what medication and for what reason? \_\_\_\_\_

Do you suffer from any ear throat or nose illness?  Yes  No  
If yes, please comment: \_\_\_\_\_

Have your tonsils or adnoids been removed?  Yes  No

Do you bleed longer or cuts take longer to heal than normal?  Yes  No

Have you ever suffered from any of the following illnesses:  Yes  No  
Hepatitis, tuberculosis, allergies? If so, when did they occur? \_\_\_\_\_

Are you hypersensitives to any medication?  Yes  No

Have you ever had an accident concerning your head/neck?  Yes  No

For female Patients: are you pregnant? If so, how many months?  Yes  No  
If a pregnancy should develop in the course of the treatment,  
Please notify us immediately.

Have you had an x-ray treatment during the last 12 months?  Yes  No

Date: \_\_\_\_\_ Signature: \_\_\_\_\_