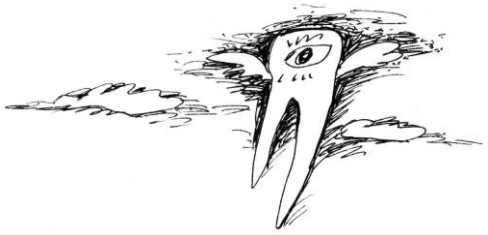
Dr. Katja Hasselberg
Zahnärztin



First name	**Last name**		
Birth date	Profession		
Street	City		
Telephone	Mobil		
Insurance	Employer		
Allowance?		Yes	No
Privat insurance - standard or basic rate?		Yes	No
Recommendation by / How did you hear about us?			

Were you in the last year in medical treatment? Due to which disease?	Yes	No
Do you take any medications? Which?	Yes	No
Do you suffer from impotence inclinations?	Yes	No
Do you wear a pacemaker?	Yes	No
Do you own a heart fit?	Yes	No
Were you x-rayed in the head area in recent times?	Yes	No
Do you bleeding long after light injuries/tooth extraction?	Yes	No
Are you addicted to alcohol?	Yes	No
Are you addicted to drugs?	Yes	No
Are you allergic to medications? Which?	Yes	No
Do you have an allergy pass?	Yes	No
Have you been treated orthodontically?	Yes	No

Have you or did you ever had any of the following diseases?

Heart / Circulatory	Yes	No
Blood / Blood clotting disorders	Yes	No
Sinuses (e.g. maxillary sinus)	Yes	No
Thyroid disease	Yes	No
Rheumatism, Osteoporosis	Yes	No
Diabetes mellitus	Yes	No
Glaucoma	Yes	No
Seizure disorders (Convulsions, Epilepsy)	Yes	No
Asthma	Yes	No
Liver (Hepatitis)	Yes	No
Tuberculosis (Tbc)	Yes	No
HIV positiv	Yes	No

Do you want to participate at our reminder service? Yes No

If your health changes during the treatment, we ask for a hint.
Please note that we can calculate a cancellation fee according to § 615 BGB for failing appointments. If you want to move an appointment, please tell us 24 hours before.

Berlin, date _____ Signature _____