



MODERNE ZAHNMEDIZIN

DR. BUTZ & PARTNER

IN DEN FÜNF HÖFEN

Registration Form and Medical History

Dear patient,

welcome to our practice. To exclude potential risks during your treatment, it is essential that you answer the questions below with great diligence. It goes without saying that all information you provide is treated confidentially among your dentists and their team. Thank you for your cooperation.

Patient

Surname: _____
Given name: _____
Date of birth: _____
Place of birth: _____
Address: _____
Private e-mail: _____

Insured person

Surname: _____
Given name: _____
Date of birth: _____

Telephone numbers

Private: _____
Mobile: _____
Business: _____

Invoice recipient

Surname: _____
Given name: _____
Address: _____

Profession: _____
Employer, location: _____

Are you eligible for benefit
from public service? yes no

Insurance company: _____

Cumpolsory insurance: yes no

How did you find out about us?



