X-ray Ordinance: (each Patient must provide the following information before the examination)

Surname/First name: _____Date of Birth: _____

Place of Residence: _____

Street and House Number: _____

1. Previous Radiographic and Nuclear medical Examinations (f. ex. Thyroid radioiodine Test)
   When:_____ What:_____
2. Old Radiographs:
   Available: _____ Unavailable: _____
3. X-ray Irradiation:
   When: _____What:_____
   X-ray examination record available: YES_____ NO_____
4. Pregnancy: YES_____ NO_____ UNCERTAIN_____

_____, the _____

(Signature Sur- and First name)

Confidentiality release

Dr. Katrin Nauert
Kieferorthopädin
Qualitätsmanagement nach DIN EN ISO

Hereby I release

Mrs. Dr. Katrin Nauert with the Practice in Sulzbach with regard to the dental/orthodontic treatment preformed with me /my child _____

(Name of the Patient/ Name of the Child)

against my dentist from the legal secrecy.

I agree to the transfer of treatment documents.

_____, the _____

(Signature Sur- and First name)