NATRAIL

Immunologic Dental Clinic
Private Tagesklinik für immunologische Zahnheilkunde

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Registration Form and Questionnaire

Generality ***(Please write in block capitals)***

Surname: _____

First name: _____

Street: _____

ZIP, City: _____ _____

Country: _____

Email: _____

Phone: _____ Cell: _____ Fax: _____

☐ male ☐ female Date of birth: _____

Test of your choice (please mark with a cross)

☐ ☐ **Test 1 - Short Panoramic X-ray Test - US$ 142.00 / Euro 110.00 /CHF 134.00**

<u>Testing for:</u>

Signs of chronic or acute inflammation - Heavy metal deposits in the dental roots - Loosening of the bone - Fatty degeneration due to exposure to solvents, pesticides and other environmental pollutants - Impaired healing of the dental alveoli, chronic inflammation of the jawbone - Bone pockets and bone loss with gingivitis – NICO`s (Neuralgia Inducing Cavitational Osteitis) - Bone loss around implants - The location of impacted teeth - Incomplete root fillings - Cysts and root granulomas (chronic encapsulated inflammation at the root of the tooth) - Foreign bodies, pieces of metal or root residues after extractions

☐

□ **Test 2 - 3-D Panoramic X-ray Test - US$ 322.00 / Euro 250.00 / CHF 305.00**

Testing for:

The DVT - dental scan 3 D gives you the third dimension that the panoramic x-ray cannot give.

The path of the nervus mandibularis with side branches - Bony path of the maxillary sinus - Heavy metal deposits in and near dental roots - Bone disintegration and fatty degeneration due to exposure to solvents and/or pesticides - Impaired healing of the dental alveoli, chronically inflamed sections of bone – NICO`s (Neuralgia Inducing Cavitational Osteitis)- Deep bone pockets and general bone loss due to gingivitis - Bone loss around implants - The location of impacted and excess teeth - Incomplete and overstuffed root fillings - Cysts and root granulomas (chronic encapsulated inflammation at the dental root) - Foreign bodies, pieces of metal or root residues after extractions
In addition The following areas can also be assessed:
- Frontal sinuses (lower third), ethmoidal cells, sphenoid sinus, maxillary sinus, nasal cavity
- Temporomandibular joints (degenerative changes)
- First cervical vertebra
- Dens axis position
- Bone dimension and bone density in 3D for dental implant planning

Present illnesses and disorders

Please cross out what applies to you:

□ Constipation
□ Chronic fatigue
□ Diahrrea
□ Irregular bowel movement
□ Bloatiness
□ Skin problems
□ Headaches
□ Migraine headaches
□ Allergies
□ Craving for certain foods
□ Asthma
□ Back pain
□ Joint pain
□ Muscle pain
□ Pain in whole body
□ Acne
□ Vaginal fungus
□ Fungus (skin etc)
□ Lack of motivation
□ Painful menstruation
□ Irritable bowel
□ Memory loss

□ Fibromyalgia

□ Catarrh

□ Palpitation

□ Uterus and ovary disorders

□ Difficulty with urination

□ Persistent cough

□ Chest pain

□ Urinary tract disorder

Other: _____

Operations:

□ Appendectomy

□ Tonsillectomy

□ Hysterectomy

□ Prostatectomy

□ Ovariectomy

□ Cholecystectomy

□ Thyroidectomy

Other: _____

Do you wear a pace-maker ?_____ Are you pregnant? _____

Blood pressure: _____

Have you had accidents or serious traumas in the past?

_____

Your health condition *(pls write in very clear and comprehensible handwriting):*

_____

_____

_____

_____

_____

_____

_____

_____

Questions regarding your teeth:

Your teeth have:

□ Amalgam fillings

□ Gold fillings

□ Porcelain fillings

□ Plastic fillings

□ Partials

□ Old fillings

□ Root canals

□ Teeth with big fillings

□ Bridges

□ Dentures - bottom

□ Infections

□ Dentures - top

□ Dentures (top and bottom)

When were our amalgam/gold fillings removed?_____

Did you undergo a detox treatment after removal? _____

Other:

_____

Do you take medications? If yes, which and why do you take them?

_____

Medications taken in the past_____

For cancer patients:

Did you undergo chemo or radiotherapy? If yes, when, where and why?

_____

_____

This test is carried out by Dott. O. Tapparo, in Munich Germany

>>> The results of your test will be sent to you by post, email or fax only after receipt of payment. The above price includes also the return by postal mail of your panoramic.

Place and date: _____

Signature:

_____