

REGISTRATION FOR CHILDREN AND ADOLESCENTS

Patient			
Last name, first name:		<input type="checkbox"/> male <input type="checkbox"/> female	Date of birth DD/MM/YY):
Street address:		Postal Code, City:	
Telephone No. Home:	Mobile:	Telephone No.:	
Health Insurance Company:			Your weight (kg):
Dentist, name and address:		Last X-Ray(s) of skull, jaw or teeth (date):	
Policy Holder			
Last name, first name:		<input type="checkbox"/> male <input type="checkbox"/> female	Date of birth DD/MM/YY):
Address street:		Postal Code, City	
Telephone No. Home *	Mobile*	Profession*:	Telephone No. Business*:
E-Mail:			

* if available

Consent according to § 4a Federal Data Protection Law

- I hereby agree to the electronic entry, use and processing of my personal data within the practice according to the data protection laws.
- I hereby allow the practice to request medical information required for my treatment from my dentist, family doctor or other medical professions, and I agree to the documentation and use of these data for my treatment.
- I hereby agree to the transmission of my data and treatment information to my dentist, family doctor or other medical profession (i.e. dental laboratory, pathohistological and/or microbiological laboratory, physiotherapist, speech therapist), if necessary for my treatment.

This agreement can be revoked partly or completely at any given time.

Berlin, (date):

- signature of patient / custodian -

MEDICAL QUESTIONNAIRE

Dear parents,

We care about your wishes and your child's health. Therefore, we kindly ask you to fill in this questionnaire. All information is recorded electronically and is subject to medical confidentiality and data protection.

Do you come to see us due to...

- your dentist's referral?
- recommendation by school dentist?
- recommendation by _____

Has your child ever had orthodontic treatment before?

- no
- yes
Where? _____
- unfinished treatment

Do your child's siblings currently have orthodontic treatment?

- no
- yes
Where? _____

Did the child's parents have orthodontic treatment?

- no
- mother
- father

Did/does your child have speech disorders?

- no
- yes

Did/does your child have speech therapy?

- no
- yes
when? _____

Habits

- Does/did your child
- suck his/her thumb/finger being older than four years of age?
 - use a pacifier ?
up to what age? _____
 - currently have any other habits?

When did your child get his/her first baby teeth?

Does your child take part in a cavity prevention programme at your dentist's?

- no
- yes

Does your child frequently grind his/her teeth?

- no
- yes

Allergies / Hypersensitivity

- Hay fever
- Food allergies
- Iodine
- Latex
- Band-Aid
- Antibiotics (i.e. Penicillin)
- other drugs

Which? _____

Heart/Circulation

- Heart defect
- Myocarditis
- Endocarditis
- Artificial heart valves or blood vessels

other _____

Respiratory system

- Bronchial asthma
- Pneumonia
- Tuberculosis

other _____

Metabolic disorders

- Diabetes mellitus

other _____

Skeletal system

- Arthropathy, Rheuma
- Scoliosis
- Muscular diseases

other _____

Nervous System / Psyche

- Seizures (Epilepsy)
- Paralysis
- Depression
- Anxiety disorder

other _____

Bleeding disorders

- Bleeding disorders (Haemophilia)
- Frequent nosebleed
- Bruises without injury

other _____

Immunity

- Organ transplant
- HIV positive

other _____

Did your child ever have an accident affecting the teeth, head or neck region?

Which? _____

When? _____

Does your child currently have any other diseases or disabilities?

Does your child regularly take any medication?

Name and dosage of medication:

With your signature you confirm the correctness and completeness of your details.

Date

Signature