Dear parents,

Many diseases and/or illness can be effected by dental treatment.
Please carefully complete this questionnaire so that we are better able to assist you. The information is subject to our medical confidentiality. If you have any difficulties or are unsure of how to answer individual please see one of our associates in the practice.

Patient: Birthdate M F

Parent 1: Birthdate

Parent 2: Birthdate

Address:

Alternative Address:

Telephone Mobile Email

Parent's 1 Occupation: Parent's 2 Occupation:

Insured bye the: Parent 1 Parent 2 Other

Insurance Name:

Invoice Address: Parent 1 Parent 2

Legal Guardian: Both Parent 1 Parent 2 Other

General Medical History

Has your child had or currently have any of the following diseases or illness. Please mark all that apply or emphasize as necessary.

	Heart failure/ cardiac murmur/ heart disease		Asthma/ Lung Disease
	Endocarditis risk / Heart card		Gastric Bowel Disease
	Febrile seizures or seizure disorders (Epilepsy)		Metabolic Diseases (Diabetes)
	Thyroid Disease		Genetic Defects (if yes, which one)
	Kidney Disease		Learning Disabilities/ Speech Problems/ ADHD
	Liver Disease		Mental Disabilities or Delays
	Blood Diseases		Infectious Blood Diseases (HIV, HBV, TBC)

Any other diseases not here mentioned:

Does your child take medication on a regular basis or have they recently been prescribed medication?

No Yes Name of the drug

Does your child have any allergies (allergy pass)? No Yes Which ones

Name and address of your pediatrician

Does your child currently receive regular medical care?

No Yes With whom and where

What is the reason für visiting us? What is especially important to you:

How did you hear about our practice?

	Flyer		Pediatrician
	Internet		Orthodontist
	Friend		Dentist
	Family		Other

Dental Medical History:

	Yes	No
Has your child been to the dentist before? When yes, when was the last time?		
When yes: Did any problems occur with any dental treatments, if so please explain.		
Does your child currently have any tooth aches?		
Does your child habe any visible cavities (dark spots on the teeth…)?		
Has your child had any x-rays done? When yes, when was the last time (Month/ Year) Which dentist/Orthodontist? Name and address		

Is your child undergoing speech therapy? No Yes Name

Is your child undergoing orthodontic treatment? No Yes Name

Which fluoride treatments does your child take?

Child's Toothpaste Junior/ Adult Toothpaste Fluoride None

Does your child brush their teeth on their own? No Yes

How many times a day does your child brush their teeth?

Does your child suck their fingers, knuckles or stuffed animals? No Yes until still

Has your schuld been breast fed? No Yes until still

Did your child drink from a bottle (pacifier or beak attachment oder sigg-bottle)

No Yes until still

Does your child drink to go to sleep or during the night? No Yes

Which drink does your child drink most offen (apple juice spritzer, juice, water…)?

The privacy policy for the collection of personal data is available in the practice and was given to me. Please note that you have given your consent to the termination and the recall of this data at any time in writing or by e-mail to practice (Article 7 (3) GDPR). I agree to the passing of certain data collected here to third parties (employees) for the purpose of billing /or appointment making and hereby release the dentist for the reasons mentioned above from the obligation of secrecy.

I assure, to tell about any change before the treatment.

Place/Date Sign