

REGISTRATION AND ANAMNESIS FORM

Dear parents,

welcome to our dental practice. Before we can dedicate our full attention to your child's teeth, we would like to ask you for information concerning your child's personal details, his or her state of health, as well as dietary habits. This information will help us provide your son or daughter with adequate, complete and risk-free consultation and treatment. Please read the following questions carefully and tick or complete all boxes applying to your child. All information provided is strictly confidential according to §203 StGB.

Thank you very much for your cooperation. Your KINDERZAHNÄRZTE am Ostpark team.

PATIENT REGISTRATION				
Your child's first name and surname				
Your child's date and place of birth				
Your child's address				
Do you have insurance?	Yes No Insurance Provider			
Date and place of birth of invoice recip	ent Relationship to the patient			
Address of invoice recipient				
Telephone/Mobile				
E-mail				
YOUR CHILD'S INSURANCE STATUS General health insurance Private health insurance Eligible for health-insurance Please note that you will be charged for appointments which have not been cancelled without a minimum of 24 hours notice. Please state your pediatrician:				
Where has your child received any previous dental treatment?				
Custody:	I hereby declare that I have full custody. I represent the person(s) in possession of custody, and have their consent. I do not have parental authority or custody.			
How did you find out about us?				
Friends/acquaintances	Family Search Engine Newspaper Radio			
Flyer	Dental/Health-care association Information event			
Direct mail	Jameda Doctor:			
Information desk	Others:			

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Does your child suffer from underlying diseases, or are there any spe	Does your child suffer from underlying diseases, or are there any specific diseases, allergies, or drug intolerances?				
Does your child take any medication regularly? If yes, which medication(s) and why?					
Have any of the child's parents been diagnosed with latex allergy or any drug intolerances? If yes, who and which allergies/intolerances?					
Has your child had any severe diseases or are they/have they been hospitalized?					
If your child has already received dental treatment: How would you describe your child's behavior and cooperation?					
	out would not refuse treatment	Refusal			
Do any of the child's parents suffer anxiety relating to dental treatment? Mother Father None					
Has your child sucked their thumb or used a pacifier?			_		
Yes, in the past,	until he/she was	months old	No		
How often does your child brush his/her teeth? Once a day	Twice daily	Three times			
How does your child brush his/her teeth? By him/herself	With parental guidanc	e By the parents			
Which kind of toothpaste do you use? Does it contain fluoride? Toothpaste for children with fluoride					
Toothpaste for children without fluoride Junior toothpas	te Toothpaste for adults	Unsure			
Has your child taken fluoride pills? Yes, until they were	months old	No			
Do you use fluoridated table salt? Yes No					
Was your child bottle-fed? Yes, until they were	months old	No			
Has your child been breast-fed? Yes, it is still being brea	st-fed Yes, until they were	months old	No		
What does your child drink with each meal and during the day? (Plea	se tick all that apply)				
Tab water Mineral water Mineral/bo	ottled water, flavoured	Fruit-juice			
Tea, sweetened Iced Tea Tea, unswe		Fruit juice spritzers/squas	sh		
Coke Lemonade Milk	Hot chocolate	Sports drinks (isotonic)			
How many snacks does your child have between meals? Roughly a day					
Which snacks does your child usually prefer? (Please check all that apply)					
Fruits Vegetables Yoghurt Sandwich					
Pretzels Rice crackers Cake	Chips/crisps				
		tte. Balisto. Knoppers etc.)			
Cereal bars Sweets/chocolate (for example Milchschnitte, Balisto, Knoppers etc.)					
OUR SERVICE FOR YOU					
We would like to keep you informed on upcoming appointments, and your annual check-up via e-mail or text message. We will also					
remind you of your appointments via text message and add you to our recall program.					
May we send you information on our dental practice or upcoming campaigns?					
Yes No If yes, via post	e-mail.				
With my signature, I hereby confirm the accuracy and completeness of the information I have provided above, and agree to the personal data of my child being saved.					
Furthermore, I shall inform this dental practice of any changes to this data immediately.					
Date	Signature of parent/guardia	n Mother Father 0	Guardian		