KINDERZAHNÄRZTE am Ostpark

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 recipient 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:

Please turn the page ->>

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?

☐ Cooperative ☐ Apprehensive, but 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 ☐ 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 guidance ☐ 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 toothpaste ☐ 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 breast-fed ☐ Yes, until they were ☐ months old ☐ No

What does your child drink with each meal and during the day? (Please tick all that apply)

☐ Tab water ☐ Mineral water ☐ Mineral/bottled water, flavoured ☐ Fruit-juice

☐ Tea, sweetened ☐ Iced Tea ☐ Tea, unsweetened ☐ Fruit juice spritzers/squash

☐ 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

☐ Cereal bars ☐ Fruit 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/guardian ☐ Mother ☐ Father ☐ Guardian