



Dear children, dear parents!

We are very pleased to welcome you in our dental practice. Before we can devote your dental wishes, we require besides your personal data, also information about your general health. This is important for an adequate and low-risk treatment. We will talk about the most important questions and answers in detail with you in a moment. As a matter of course all information are subject to the medical confidentiality. We would be pleased to help you if you have any questions.



1 | Personal information



CONTACT DETAILS OF THE CHILD

m f

Surname, Given name _____

Date of birth _____

Place of birth _____

Street _____

ZIP Code / City _____

Phone No. _____

Mobile _____

Your child visits a toddlers' group

a kindergarten

a school

LEGAL GUARDIAN

Child is insured through

Mother Father both

Do you have a dental insurance for your child?

Mother Father

Yes No

CONTACT DETAILS OF THE MAIN INSURED (parent)

m f

Surname, Given name _____

Date of birth _____

Street _____

ZIP Code / City _____

Phone No. _____

Mobile _____

E-Mail _____

Profession _____

Phone No. Employer _____

Employer / Company _____

INSURANCE OF THE CHILD

Health Insurance Company _____

Legally insured

Private health insurance

2 | General questions concerning your health



Name of family doctor

Contact data

DOES YOUR CHILD HAS ONE OF THE FOLLOWING DISEASES?

Heart disease, -defect or -murmurs Yes No

Labored breathing, asthma or other pulmonary disease Yes No

Diseases of liver or kidney Yes No

Infectious diseases, i.e. Hepatitis A/B/C?, Tuberculosis?, HIV? Yes No

Diabetes or Metabolic Diseases Yes No

Bleeding disorders or other blood disorders Yes No

Epilepsy Yes No

Mental impairment or disability Yes No

Speech problems, hearing and vision problems (deafness) Yes No

Proven allergies Yes No

Learning disability / AD(H)S Yes No

Increased or low blood pressure Yes No

Is your child vaccinated against tetanus? Yes No

Is your child taking any medication on a regular basis? Yes No

Does your child have any other diseases? Yes No

Were X-ray images of your child teeth and/or head taken before? Yes No

When have they been made and who has done the X-ray images?

Heart disease record card since:

Which?:

Which or for what?

Allergy pass since:

too high too low

Which?:

Which?:

DO YOU WANT TO BE REMINDED OF YOUR NEXT APPOINTMENT?

Yes No

via phone call via postage via E-Mail

HOW DID YOU FIND OUT ABOUT US?

Recommendation from _____

Internet Telephone directory

Kindergarten/daycare/school

Other _____



Appointments

In order to avoid latency, your appointments are scheduled exclusively for our young patients. In case you are unable to attend your appointment we would like to ask you to inform us **at least 24 hours before** in order to reschedule. Otherwise we would need to charge the costs caused by not attending the appointment.

Health Insurance Card

We require your health insurance card at every visit to our dental practice. If it is not present 14 days after your treatment, we consider you as a private patient and you will receive an invoice.

Declaration

I have filled out this questionnaire with my child to the best of my knowledge and confirm with my signature that the provided information about my child are complete and correct. Furthermore, I will inform you if there are any changes in the provided information.

Place, Date

Signature of legal guardian