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Hello and welcome to our dental office!

We are happy that you trust us with your child's dental health. To be able to provide your child with individual and risk-free dental care we ask you to fill in your child's personal as well as medical data.

Medical confidentiality applies.

Personal data

Patient

☐ Girl
☐ Boy

_____ _____ _____
Name First name Birthday

"Nickname"_____ Brothers/ sisters: ☐ Yes ☐ No

Hobbies, pets, etc. _____

Personal data of insured parent

☐ **Mother**
☐ **Father**

_____ _____ _____
Name First name Birthday

Address _____
Street, no., postal code, city

Phone (home) _____ Phone (work) _____

Mobile: _____ Email address _____

Parents separated ☐ Yes ☐ No

Only if address is different:

☐ **Mother**
☐ **Father**

_____ _____ _____
Name First name Birthday

Address _____
Street, no., postal code, city

Phone (home) _____ Phone (work) _____

Mobile: _____ Email address _____

Health insurance ☐ "gesetzlich" ☐ private _____

Co-insured with ☐ mother ☐ father ☐ EU insurance

Patients with "gesetzliche" insurance
We require your health insurance card with every appointment at our office. If you can't provide the card within 14 days of the treatment we consider you as a private patient and you will receive an invoice according to GOZ (Gebührenordnung für Zahnärzte/ dental fee schedule) standards.

Supervising paediatrician _____ _____
Name City

How did you get to know about our dental office?

☐ Telephone book ☐ Internet ☐ passing by ☐ Yellow pages ☐ Friends/ relatives _____

☐ Supervising paediatrician ☐ Dentist: _____ _____
Name City

☐ I wish for my child to be included into the recall system and get a reminder by phone to schedule a biannual appointment.

Please turn over

Medical data

Does your child have any severe illnesses? ☐ Yes ☐ No
If yes, which? _____

Has your child been diagnosed with a heart defect or heart murmurs? ☐ Yes ☐ No
Endokarditis? ☐ Yes ☐ No

Is your child under any medical treatment at the moment? ☐ Yes ☐ No
If yes, for what reason? _____

Does your child take any medication? ☐ Yes ☐ No
If yes, which? _____

Did your child show any unusual reaction to medication yet? ☐ Yes ☐ No
If yes, towards what/ what kind of symptoms? _____

Does you child have any allergies? ☐ Yes ☐ No
If yes, what kind? _____

Has your child been hospitalized? ☐ Yes ☐ No
If yes, why? _____

Does your child have any physical and/ or mental disabilities? ☐ Yes ☐ No

If your child suffers any of the following please mark: ☒

☐ Adenoids ☐ Asthma ☐ (blood) coagulation disorder ☐ Convulsions/ neuro seizures
☐ Defective hearing ☐ Diabetes ☐ Heart problems ☐ Kidney problems
☐ Impaired vision ☐ Infectious diseases (e.g. HIV, hepatitis, tuberculosis)
☐ Rheumatism ☐ Spasticity ☐ Tumours ☐ Other _____

Your child's oral health is our main concern!

What is the reason for your visit today? _____

Does your child have toothaches? ☐ Yes ☐ No

Has your child been to a dentist before? ☐ Yes ☐ No

If yes, what kind of treatment was done? _____

Where x-ray pictures taken of your child's teeth? ☐ Yes ☐ No

What is your child's attitude towards dentists? _____

Does your child take fluoride tablets? ☐ Yes ☐ No

Does your child still drink from a baby bottle, feeding cup etc.? ☐ Yes ☐ No

Does you child get orthodontic treatment at the moment? ☐ Yes ☐ No

Consent to treatment:
I agree to the dental and dento-surgical treatment of my child including the use of necessary and advisable local anaesthetics, nitrous oxide, sedatives, x-ray, and other diagnostic measures by Dr. Topf and Dr. Arab as well as their employees.

A note on time management:
We constantly strive to spare you excessive waiting time. Thus, we ask you to **cancel appointments minimum 24 hours in advance** if you are not able to keep them. **We are entitled to charge for missed appointments according to GOZ standards even if you are not privately insured.** Please note that we have to integrate patients with pain into our schedule and thus delays may occur.

Data security:
Information about the elicitation and processing of personal data according to the EU General Data Protection Regulation (GDPR/ DSGVO) may be obtained at our website or our clinic's reception desk at any time.

Thank you for your cooperation! Please let us know any changes to the above data immediately. With your signature you agree to the exchange of medical data between our dental office and the orthodontic office of Edward Jahn.

_____ _____
Date Signature