REGISTRATION AND ANAMNESIS FORM

KINDERZAHNÄRZTE AM OSTPARK

DEAR PARENTS,

welcome to our dental practice. Before dedicating our full attention to your child's teeth, we would like to ask you for information concerning your child's personal details, 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

Date and place of birth of invoice recipient

Address of invoice recipient

Phone

E-Mail *Voluntary information – if you wish to be contacted by us on medical matters via this medium.

Mobile *Voluntary information – if you wish to be contacted by us on medical matters via this medium.

Do you have insurance?

○ Yes ○ No

Insurance Provider

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

○ Sole custody.
○ Joint custody
○ I am no parental guardian

How did you find out about us? *Voluntary information - we collect statistics on this in-house.
Please tick as appropriate

○ Friends | Acquaintances ○ Family ○ Search Engine ○ Newspaper ○ Radio ○ Flyer
○ Dental | Healthcare association ○ Information event ○ Direct mail ○ Information desk ○ Jameda
○ Doctor | Physician: _____ ○ Others: _____

Does your child suffer from underlying specific diseases, allergies or drug intolerances?

Does your child take any medication regularly? If yes, which medication(s) and why?

Has any of the child's parents ever had a reaction or allergy to an antibiotic, latex or other medication?

Has your child ever been hospitalized or been treated in an emergency department?

PLEASE TURN THE PAGE

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

Does any of the child's parents suffer anxiety relating to dental treatment?
○ Mother ○ Father ○ None

Does your child have a history of a sucking habit after one year of age?
○ Yes, finger | thumb until it was _____ years old ○ Yes, pacifier until it was _____ years old ○ No

How often does your child brush his | her teeth? ○ Once a day ○ Twice daily ○ Three times daily

How does your child brush his | her teeth? ○ By him | herself ○ With parental guidance ○ By the parents

Which kind of toothpaste does your child use?
○ Toothpaste for children without fluoride ○ Toothpaste for children with fluoride ○ Junior toothpaste
○ Toothpaste for adults ○ Unsure

Has your child taken fluoride tablets? ○ Yes, until it was _____ months old ○ No

Do you use fluoridated table salt? ○ Yes ○ No

Was your child bottle-fed? ○ Yes, until it was _____ months old ○ No

Has your child been breast-fed?
○ Yes, it is still being breast-fed ○ Yes, until it was _____ months old ○ No

What does your child drink with each meal and during the day?
Please tick as appropriate

○ 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 frequently does your child have snacks? Roughly _____ a day

Which snacks does your child usually prefer?
Please tick as appropriate

○ Fruits ○ Vegetables ○ Yoghurt ○ Sandwich
○ Pretzels ○ Rice crackers ○ Cake ○ Chips | crisps
○ Cereal bars ○ Fruit bars ○ Sweets | chocolate (e.g. Milchschnitte, Balisto, Knoppers etc.)

OUR SERVICE FOR YOU

We would like to keep you informed on upcoming appointments and your semi-check-up via e-mail or text message.

May we send you information on our dental practice or upcoming campaigns? ○ Yes ○ No
If yes, via ○ post ○ e-mail

I ACCEPT THE TERMS OF PRIVACY POLICY.
This declaration of consent is voluntary and can be revoked at any time (Art. 7 Abs. 3 Satz 2 DSGVO).

We would like to point out that in the case of laboratory diagnostics (laboratory | pathology), your data on the insurance card must be forwarded to the laboratory.

Date

Signature of parent | guardian
○ Mother ○ Father ○ Guardian

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.

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