Kinderzauberzähne

Gemeinschaftspraxis für Kinder- & Jugend-
zahnheilkunde und Kieferorthopädie

Registration form with medical history

Child (First and last name) born on Place of birth

Father (First and last name) born on

Mother (First and last name) born on

Street _____

Zip code/city _____

Email _____

Phone _____ Mobile _____

Who is the invoice recipient? ☐ Mother ☐ Father *(only if the patient has private insurance)*

Health insurance

Legal insurance _____ ☐ compulsorily insured ☐ voluntary

Private supplementary insurance ☐ Yes ☐ No

Statutory health insurance _____

The child is also insured with ☐ Mother ☐ Father

The custody has ☐ Mother ☐ Father

No custody of parents available = guardian _____ Phone _____

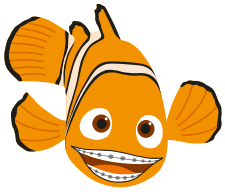
Name of the pediatrician _____ City _____

I confirm that I have provided the above information to the best of my knowledge and belief.
Note: If we do not receive the KV card within 10 days, we reserve the right to issue a private invoice for the services rendered. Please understand that we have to charge a cancellation fee of 75,- Euro per approached half hour for reserved appointments that are not kept without cancellation, unless the gap in the appointment can be filled by another patient. (according to § 615 BGB)

_____ _____

City, Date Signature

Dr. Miriam Landgraf, Zahnärztin | **Dr. Margita A. Beck,** Zahnärztin | **Dr. Luise Sauer,** Kieferorthopädin
Alleestraße 24, 65812 Bad Soden / Taunus | Phone: +49 6196/9996955 | Fax: +49 6196/9996956
info@kinderzauberzaehne.de | **www.kinderzauberzaehne.de**



General anamnesis

Is the child currently receiving (non-dental) **medical treatment?**

☐ **Yes** due to _____ ☐ **No**

Doctor _____

Does the child take medication regularly?

☐ **Yes** ☐ **No**

Which? _____

Heart/Circulation	**Yes**	**No**
Heart failure	☐	☐
Heart murmurs	☐	☐
Other _____		
Heart Passport	☐	☐

Metabolism	**Yes**	**No**
Diabetes	☐	☐
Hyperthyroidism	☐	☐
Hypothyroidism	☐	☐
Other _____		

Nervous system	**Yes**	**No**
Epileptiform seizures	☐	☐
Cramps	☐	☐
Neurol. disorders _____		

Bleeding disorders	**Yes**	**No**
Hemophilia (Bleeder)	☐	☐
Anemia (Bloodpoverty)	☐	☐
Other _____		

Allergies	**Yes**	**No**
Asthma	☐	☐
Allergy	☐	☐
Reacts allergic to:		
_____		
Latex	☐	☐
Allergy Passport	☐	☐

Infectious diseases
(these are, for example, hepatitis, tuberculosis, HIV, etc.)

	Yes	**No**
	☐	☐
If yes, which _____		
Chronic		
Respiratory	☐	☐
If yes, which _____		

Hospitalizations	**Yes**	**No**
	☐ _____ (Month/Year)	☐
Reason _____		
Hospital _____		

Other diseases, syndromes etc.

_____

Special features _____

Accident mouth and face

☐ **Yes** ☐ **No**

Habits	**Yes**	**No**
Thumb	☐ until _____	☐
Finger	☐ until _____	☐
Pacifier	☐ until _____	☐

Bottle/Breast	**Yes**	**No**
Breastfeeding	☐ until _____	☐
Bottle	☐ until _____	☐
☐ night ☐ day	Content _____	

Logopedic treatment

☐ **Yes** ☐ **No**

_____ _____

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