HEIDELBERGER Milchzähne

Admission Form

Child / Patient	Surname .... First name ....
	Date of birth .... Place of birth .... Female ◯ Male ◯
Siblings	No ◯ Yes ◯ Surname .... First name ....
	Surname .... First name ....
Parent / guardians	Mother ◯ Father ◯ Guardian ◯
Health insurance provider	.... Eligible for financial assistance ◯ Voluntary insurance ◯ Private supplementary insurance ◯
Parents' profession	Mother .... Father ....
Mother (or guardian)	Surname .... First name .... Date of birth ....
Address	Street / House number ....
	Postcode/ZIP / Town .... Email ....
	Daytime telephone number .... Moblie ....
Father	Surname .... First name .... Date of birth ....
Address	Street / House number ....
	Postcode/ZIP / Town .... Email ....
	Daytime telephone number .... Moblie ....
Insurance policy holder	Mother ◯ Father ◯
Paediatrician	Name, adress ....

Does your child suffer from / has your child ever suffered from any of the following conditions?

Asthma	Yes ◯ No ◯	Infectious diseases (HIV, Hepatitis...)	Yes ◯ No ◯
Chronic bronchitis	Yes ◯ No ◯	Epilepsy (seizures)	Yes ◯ No ◯
Heart conditions/ 'Herzpass'	Yes ◯ No ◯	Visual problems	Yes ◯ No ◯
Kidney / liver disease	Yes ◯ No ◯	Hearing problems	Yes ◯ No ◯
Diabetes / metabolic disorders	Yes ◯ No ◯	Speech problems	Yes ◯ No ◯
Genetic illnesses	Yes ◯ No ◯	Learning difficulties / ADHD	Yes ◯ No ◯
Blood clotting disorders	Yes ◯ No ◯	Mental disabilities	Yes ◯ No ◯
Tumours	Yes ◯ No ◯	Physical disabilities	Yes ◯ No ◯

Other diseases .... Allergies (e.g. latex) ....

Does your child take any medication regularly? No ◯ Yes ◯ ....

Has your child been vaccinated against tetanus? No ◯ Yes ◯

Has your child ever been treated as an inpatient in hospital?

No ◯ Yes ◯ Reason ....

Were there any complications / anomalies during pregnancy or birth? (Premature birth/ Forceps delivery)

No ◯ Yes ◯ ....

How does your child feel about visiting the dentist?

Positiv ◯ Neutral ◯ anxious ◯ fear of injections ◯ first dental visit ◯

What is the reason for your visit today? ....

Has anything ever upset your child during past dental visits?

....

Name of previous dental practice ....

Is your child receiving orthodontic treatment No ◯ Yes ◯ Where? ....

Was your child breastfed? No ◯ Yes ◯ How long? ....

Is / was your child bottle fed? No ◯ Yes ◯ Until what age? ....

When? Mornings ◯ Afternoons ◯ Evenings ◯ Bedtime ◯ During the night ◯

What is your child's main drink? ....

Does / did your child suck their thumb? No ◯ Yes ◯ Until what age? ....

Does / did your child have a dummy / pacifier? No ◯ Yes ◯ Until what age? ....

How often does your child have sweets/candy? Several times a day ◯ Once a day ◯ Rarely/ not everyday ◯

Does your child take fluoride? If yes, in what form? No ◯ Yes, in: toothpaste ◯ Salt ◯ Tablets ◯

Who brushes your child's teeth? The child ◯ Mother / father ◯

How often do you /does your child brush their teeth? .... **Is your child motivated?** Yes ◯ No ◯

Does your child attend: Nursery ◯ Childminder ◯ Kindergarten ◯ School ◯

Any additional information regarding your child that you think we should be aware of?

....

How did you hear about our practice? ....

Would you like to be reminded of your child's next appointment?

Yes, by: Phone call ◯ Email ◯ SMS ◯ No thanks ◯

....

Date, Signature of Legal Guardian