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# REGISTRATIONFORM

Kieferorthopädische Praxis für Kinder und Erwachsene

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## Dear Patients,

welcome to our practice! By answering the following questions you enable us to make a careful analysis. Your information will of course be treated confidentially. Thank you.

**Patient's last name, first name** \_\_\_\_\_

Date of birth \_\_\_\_\_  female  male

Address \_\_\_\_\_

Horne phone \_\_\_\_\_ Mobile phone \_\_\_\_\_

E-Mail \_\_\_\_\_ Profession \_\_\_\_\_

**Name of the insured parent/guardian/tutor** \_\_\_\_\_

Date of birth \_\_\_\_\_  female  male

Address \_\_\_\_\_

Profession \_\_\_\_\_ Mobile phone \_\_\_\_\_

*If the insured person is not the legal guardian, please complete the following*

**Name of legal guardian** \_\_\_\_\_

Date of birth \_\_\_\_\_  female  male

Secondary Address (if applicable) \_\_\_\_\_

Profession \_\_\_\_\_ Mobile phone \_\_\_\_\_

**Who will receive the invoice/bills?**  parent  legal guardian

## Health insurance of the patient

private health insurance by \_\_\_\_\_

compulsory (german statutory) health insurance by \_\_\_\_\_

**Name of your attending/family dentist** \_\_\_\_\_

Whom may we thank for referring you to our office?  Dentist  Family/Friend

Internet  Practice sign

Other \_\_\_\_\_

Please turn over



Have you / has your child had any recent X-Rays taken?  No  Yes *When?* \_\_\_\_\_

Have you / has your child been orthodontically treated?  No  Yes *Where?* \_\_\_\_\_

Has any siblings been orthodontically treated?  No  Yes *Where?* \_\_\_\_\_

### Have you / has your child any of the following diseases?

- Heart diseases
- Diabetes
- Infections (HIV, Hepatitis)
- TMD
- Colds/ Flu
- Epilepsy
- Blood disorders
- ADD / ADHD
- Allergies to \_\_\_\_\_
- Surgery *if yes, please explain* \_\_\_\_\_

Other disease or physical or mental disorders

\_\_\_\_\_

Are you / is your child on any medications?  No  Yes *Which?* \_\_\_\_\_

Is there a history of trauma to the head, face or teeth?  No  Yes *When?* \_\_\_\_\_

Do you / does your child grind/clench his/her teeth at night?  No  Yes

Do you / does your child snore?  No  Yes

Has a speech therapy been carried out?  No  Yes

Do you have / has your child any habits? (e.g. thumb/finger sucking)  No  Yes *Which?* \_\_\_\_\_

### Why do you want orthodontic treatment?

\_\_\_\_\_

\_\_\_\_\_

I authorize the performance of diagnostic X-rays of my child if considered necessary or advisable.  
I will be informed priorly.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and **that it is my responsibility to inform of any changes in the future**

\_\_\_\_\_

Date and Signature