Zahnplanet
Zahnarztpraxis für Kinder

Gemeinschaftspraxis
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Welcome

last name	first name	nickname
date of birth	sex	hobbies
street/ house number	postal code/ place	phone number/ mobile
mother (first and last name)	title	date of birth
father (first and last name)	title	date of birth

How is your child insured, by whom? ☐ compulsorily ☐ private ☐ mother ☐ father

Name of health insurance

pediatrician: name address phone

How did you notice us?

☐ doctor/ friends ____________________ ☐ internet/ phone book ☐ other__________________

Would you like to be reminded one day before your agreed date? ………………………..**yes**☐ **no**☐

Would you like to be included in our recall- system for regular check ups? …………….**yes**☐ **no**☐

I have carefully read and understood the health questionnaire and answered the questions to the best of my knowledge.

München, am_______________

___________________________________ ___________________________________

signature of mother/ father
or legal guardian

signature of dentist

If you are unable to attend an appointment, please cancel 24 hours in advance. In the case of unforeseen missed appointments, we reserve the right to charge a default fee. Your child is also looking forward to a quick date!-

please turn over –

General health questions

1.Are allergies known to your child? **yes**☐ **no**☐
if so, which?____

2.Is your child vaccinated against tetanus? .... **yes**☐ **no**☐

3.Was/ is your child ill with one of the following diseases? Please tick the appropriate box!

☐ blood disease (e.g. anemia, leukemia, hemophilia)
☐ cardiac disease ☐ congenital heart defect
☐ epilepsy ☐ fever convulsions
☐ neurodermatitis
☐ hearing problems ☐ deafness
☐ defect of vision ☐ blindness
☐ muscle weakness ☐ spasticity
☐ pulmonary disease ☐ asthma
☐ infectious disease (e.g. HIV, hepatitis, tuberculosis)
☐ liver disease ☐ kidney disease
☐ gastro- intestinal disease
☐ diabetes ☐ other metabolic disease
☐ mental handicap

4.other general diseases .... **yes**☐ **no** ☐
if so, which?____
5. other syndromes ……………………….. **yes**☐ **no** ☐
if so, which? ____
6. Does your child take regular medication? .... **yes**☐ **no** ☐
if so, which?____

7. Did your child already have three- day fever / measles / chickenpox / scarlet fever
yes, at the age of: __________________ / ______ / __________ / _________

8. Did your child ever have an anesthetic? …………………………………… **yes**☐ **no**☐
if so, where anesthesia was done, when and where?
Where there any complications?____

9. Have there been health problems in pregnancy/ in the first 2 years of life? **yes**☐ **no**☐
if so, which?____

Dental question

10.Does your child still drink from the baby bottle? ....**yes**☐ **no**☐
11.How long was the child breastfed / bottlefed?______________________
12.What the bottle contents?____
13.Was/ is a pacifier used / sucked on the thumb? .... **yes**☐ **no**☐
14.Did or does your child get fluoride?.. **yes**☐ **no**☐
if so, in which form? pills / fluoride salt / toothpaste / fluoride gel
15. How does your child brush teeth? self / under supervision / parents brush / manually / electrical
how often?____
16. Did your child ever have an accident that affected their teeth? …………….. **yes**☐ **no**☐
17. What is the reason for today’s dental visit?____________________________
18. Is it the first dental visit for your child? …………………………………… **yes**☐ **no**☐
If not, when and were was your child?_______________________________
19. Have there been negative visits on the dentist? ………………………………**yes**☐ **no**☐
if so, what was your child afraid of?________________________________

Questions to the parents	**mother**	**father**
1. Are allergies known to you? If so, which?	**yes**☐ **no**☐	**yes**☐ **no**☐
2. Do you tend to caries/ gum bleeding/ tartar?	**yes**☐ **no**☐	**yes**☐ **no**☐