Registration sheet - children

smile pasing
ORTHODONTICS
Lara Muncker-Wouters
Specialist Dental Practitioner in Orthodontics

Welcome to our practice! We would like to talk about your orthodentic wishes and will give you the right advices for your treatment . As well as your personal data, we need at your next appointment information about your general state of health. Your information will be kept in confidence. They are liable to the medical confidentiality appropriate §203 of the StGB as well as the terms of data privacy.

patient

last name:

first name:

street, no:

ZIP/city:

date of birth:

phone-No.:

mobile:

health insurance:
(name and city)

insurant

last name:

first name:

date of birth:

employer:

occupation:

phone: (business)

first name of husband:

birth of date:

employer:

occupation:

mobile:

e-mail:

type of insurance

- ☐ legally insured
- ☐ voluntarily insured
- ☐ privately insured
- ☐ tariff for privately insured
- ☐ additional insurance for orthodontics
- ☐ allowance

name of dentist:

city:

name of general practitioner:

city:

How did you hear about us?

- ☐ friends / relatives
- ☐ internet (internet-portals)
- ☐ get more information on: www.smile-pasing.de
- ☐ advertising (daily press/magazines/ etc.)
- ☐ other:

I agree that my data or the patients data will be saved and will eventualy given to a billing company.
In case of a handover or the employment of a representative, I agree to commit my personal data to the follower.

PLEASE NOTICE THE REAR PAGE!

date:

signature:

Registration sheet - adults

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general state of health

- Do you have general diseases? (heart, liver, kidneys, blood coagulation disorder, diabetes) yes ___ no ___
  or infectious diseases (hepatitis, AIDS)?
  If yes, which? _____
- Do you ingest medicine regularly? yes ___ no ___
  Which and for what? _____
- Are you alergic or incompatible to anything? yes ___ no ___
  Which? _____

Questions to X-rays

- Did your head/jaw has been X-rayed in the last 12 months? yes ___ no ___
- Women: Are you pregnant? If yes, which month? _____ yes ___ no ___

Questions for orthodentic reasons

- Did you already have an orthodontic treatment? yes ___ no ___
  Which doctor? _____ Was it interrupted? yes ___ no ___
- What annoys you most about your teeth and jaw? yes ___ no ___
- Do you often have headache or feel pain in your face or when you chew? yes ___ no ___
  Which? _____
- Do you have bruxism? yes ___ no ___
  Till when? _____
- Did you have accidents involving your teeth or your jaw? yes ___ no ___
  If yes, which? _____
- Are you breathing through your mouth, have you often been cold or are you snoring? yes ___ no ___
  What? _____
- Has your child ever been under medical treatment of an ENT doctor? yes ___ no ___
  if yes, was has been done? ___ tonsillectomy ___ adenoids removed
  other: _____
- Does tongue thrusting or lip-/nail biting exist? yes ___ no ___
  Till when? _____
- Did siblings have a orthodontic treatment? yes ___ no ___
  Which doctor? _____
- Do relatives have similar defective positions? yes ___ no ___
  Which and who? _____
- Does aplasia exist in your family? yes ___ no ___
  Which and who? _____
- When does the first milk teeth appear? Before 6th /7th month: _____ after 8th month: _____
- Does a speech disorder exist? (eg. sigmatism) or has a logopedic treatment been realized? yes ___ no ___
  If yes, when? _____
- Did or does your child suck the thumb, bite nails or does he/she suck a dummy? yes ___ no ___
  If yes, thill when? _____

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