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Registration form for Children

Child:
Last name: _____
First name: _____
Date of birth: _____
Address: _____
_____
Phone: _____
Health insurance
(private/statutory): _____

Member of health insurance:
Last name: _____
First name: _____
Date of Birth: _____
Address: _____
_____
Phone : _____
Occupation: _____
Employer: _____

In case of private payment please send the invoice to:
Name: _____
Address: _____
_____
Health insurance
(private/statutory): _____

Paediatrician: _____

Legal Guardian O Father O Mother O Other:
_____

Medical history - Special details:
What is the reason for today`s consultation? _____
When was the child`s last visit at a dentist? _____
Has your child suffered from tooth ache before? O yes O no
Has your child had any injuries in the mouth or jaw area? O yes O no
Has your child ever had bad experience with a dentist? O yes O no

Medical history - Common details:
Has your child ever suffered from...
O heart desease O kidney desease
O infectious desease (HIV, Hepatitis or TB) O desease of the lung
O asthma O learning impediment (ADHD)
O other: _____
Does your child have any allergy or is ist sensitive to some metals or pharmaceuticals? O yes O no
If so, which ones? _____
Is your child under regular medication?
If so, which ones? _____
Do you provide your child with: O toothpaste for children with fluoride O fluoride tablets
O toothpaste for adults/juniors with fluoride O fluoride salt

Medical History of the parents:
Does one of the parents suffer from an allergy?
If so, which one: _____
Is one of the parents prone to.... O dental caries O tartar
O bleeding of the gum O dentist fright

Would you like to be reminded of your child`s routine dental check-ups? O yes O no
How did you learn about our dentl surgery? _____

To avoid long waiting times for all patients please be on time when you have an appointment and if you cannot come please call at least 24 hours before your appointment. Otherwise **we appologize that it ist neccessary to invoice you 49 euro per every 30 minutes. This applies not if you miss the appointment without any fault on your part** and tell the reasons in written form
With my signature I ensure that I filled the form truthfully. I will inform my dentist about all changes immediately**.**

Köln, _____
(date, signature)#