Dr. Carola Seekamp
Dr. Sara Nasiri
Fachzahnärztinnen für Kieferorthopädie

Application Form Youngsters

Dear Patient,

Welcome to our practice. In order to help you in the best possible manner, we kindly ask you to fill in this application form.

Please provide us with any existing, recent dental x-rays. This will allow us to save time and protect your child's health from unnecessary radiation. In urgent cases, please bring a reference note from your dentist.

patient surname ____ patient first name ____ date of birth ____

address | street, number ____ postal code ____ city ____

telephone number:

mobile number ____ home number ____ office number ____

email address ____ school of child ____

name of main insured person (contract owner) | first name ____ date of birth ____

name of insurance ____ insured with: ☐ father ☐ mother

☐ legally insured ☐ privately insured ☐ voluntarily ☐ legally insured with private supplementary orthodontic insurance

profession + employer ____

Who recommendet us to you? ____ Please provide the name of your family dentist. ____

Health Questionnaire

What is the reason for your visit? ____

Are you coming on the recommendation of your dentist? ☐ yes ☐ no

Has your child ever been under orthodontic treatment? ☐ yes ☐ no

If yes, when? ______________________________ Where? ______________________________

Has your child been x-rayed? ☐ yes ☐ no If yes, was it in the head area? ☐ yes ☐ no

Was the birth development: ☐ normal ☐ complicated: ________________________
☐ labor induce ☐ PDA ☐ c-section

Infant nutrition: breast feeding until _______ month; feeding bottle until _______Year

Did your child suck his/her thumb? ☐ yes ☐ no

If yes, for how long? ____

Does your child snore? ☐ yes ☐ no Does your child grind one`s teeth? ☐ yes ☐ no

Does your child suffer from?

- Heart or circulatory disturbance? ☐ yes ☐ no
- Blood diseases respiratory problems or haemophilia? ☐ yes ☐ no
- Asthma, hay fever, food allergies or any other allergies? ☐ yes ☐ no

If yes, which allergies? ____

Does your child take regular medication? ☐ yes ☐ no

If yes, which? ____

Does your child have diabetes or any other metabolic disorder? ☐ yes ☐ no

Which children`s diseases did your child have? ____

____

Has your child had their tonsils taken out? ☐ yes ☐ no

Has your child been to the hospital or any other medical treatment? ☐ yes ☐ no

If yes, what was the reason for the medical treatment: ______________________________

Does your child wear orthopedic shoe inserts? ☐ yes ☐ no

Did your child inherit jaundice or any serious infectious disease? ☐ yes ☐ no

What is the name of your family doctor or paediatrician: ______________________________

Does your child play any musical instrument? ☐ yes ☐ no
If yes, which? ____

Does your child do any sport? ☐ yes ☐ no
If yes, which and how many hours per week? ______________________________

Does your child need a mouthguard? ☐ yes ☐ no

Has your child ever been to speech therapy? ☐ yes ☐ no

If yes, when? ______________________________ Where? ______________________________

If your health status changes, we ask for immediate notification.
For further information, please visit our Homepage www.kfo-charlottenburg.de

Thank you! Your practice team

Date ______________________________

Signature: ______________________________ ______________________________

Countersignature d. Practice

Schöne, gesunde Zähne – gut lachen!