Medical History Sheet Teens - New

PATIENT:

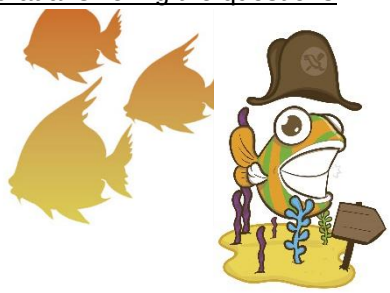
name	surname(s)	date of birth

Insured:

name	surname(s)	date of brith
street	zip code / city	phone
insurance	email	mobile
employer	phone: office / daytime	

Welcome on Board at the "Seasmile". We are glad that you are there!

The answering of the following questions is voluntary. We indicate that answering the questions is necessary to provide an appropriate treatment/care.



1. **Attending doctors:**
   Pediatrican_____
   Dentist_____

2. **Do you have any severe systemic disease e.g.**

☐ sore throat/rickets	☐ heart disease	☐ jaundice	☐ blood pressure
☐ diabetes	☐ epilepsy	☐ asthma	☐ liver
☐ kidney	☐ AIDS	☐ hepatitis	☐ tuberculosis
☐ gastrointestinal	☐ thyroid	☐ migraine	☐ arthrosis
☐ other diseases:			

4. **Do you have problems with the blood coagulation or is there a family history with such a problem?** no ☐ yes ☐, what? _____

5. **Do you take prescription drugs regularly?** no ☐ yes ☐ If yes, which ones?_____

6. **Do you tend to have allergic reactions?**

   ☐ hay fever ☐ Contact with latex
   ☐ rash / eczema ☐ other: _____
   ☐ asthma
   ☐ drugs/active ingredients, which ones: _____

7. **Do you have any therapies?**

   ergo therapy ☐ speech therapy ☐ physiotherapy ☐ psychotherapy ☐

8. **Are you happy with your teeth?** no ☐ yes ☐

   If no, what would you like to change? _____

9. **Did you have any accidents affecting your teeth or jaws?**

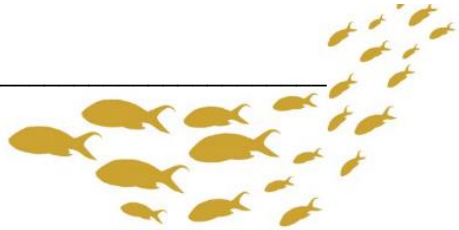
   no ☐ yes ☐ If yes, which ones?_____

10. **Do you have any crooked teeth?**

    no ☐ yes ☐ If yes, which ones?_____

11. **Are you already having an orthodontic treatment?**

    no ☐ yes ☐ If yes, who is the attending orthodontist? _____



12. **Do you use sport bottles?** no ☐ yes ☐

13. **If yes, how often, how long and what do you drink?**

    _____

14. **How often daily do you brush teeth?** _____

    with a regular tooth brush ☐ electrical tooth brush ☐

15. **Do you use fluorids regularly?**

    no ☐ yes ☐ If yes, which ones?_____

    Tooth paste ☐ gels ☐ salt ☐ mineral water ☐

16. **What is the reason for your visit today (check-up, loss of a filling, teeth cleaning, braces, pain etc.)?**

_____

17. **How did you take notice of our clinic (referral, friends, etc.)?**

_____

18. **Shall we remind you for your semiannual check-ups?** no ☐ yes ☐

Thank you very much and have a good time!

Declaration oft he parent or legal quardians:

We assure you the confidential handling of your data. Upon the admission of another practitioner, the departure of a practitioner or the divestment of the practice, we will hand over your treatment data to the new practitioner or to the successor. However, as part of an introductory or transfer agreement, we will ensure that the treatment data are only used if you decide to become a patient with the respective treatment provider. With this limited declaration of secrecy, you ensure that you always receive optimal dental care and important data is always available to the practitioner of your choice.

I have completed this questionnaire with my son / daughter together, With my signature, I confirm the accuracy of the information, have taken note of all facts and I agree with them, especially with the processing of the data.

Please let us know any changes in your address or other information!

_____

date signatur of the parent/legal guardian