Medical History Sheet Kids - 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 oft he following questions is voluntary. We indicate that answering the questions is necessary to provide an appropriate treatment / care for your child.

1. **Attending doctors:**

   Pediatrican_____ Dentist_____

   Did a doctor refer you to us? If yes, which ones?

   name: _____

   address (street / zip code / city):

   _____

2. **Does your child have a systemic disease e.g.**

   heart ☐ lungs ☐ liver ☐ kidneys ☐ epilepsy ☐ asthma ☐

   other diseases ☐: _____

3. **Does your child take prescription drugs regularly** yes ☐ no ☐

   If yes, which ones? _____

4. **Does your child tend to have allergic reactions?**

   Hay fever ☐ rash / eczema ☐ asthma ☐

   Drugs / active ingredients ☐: _____

5. **Does your child have problems with the blood coagulation or is there a family history with such a disease** yes ☐, what? _____ no ☐

Please turn →

6. **Does your child go to therapy?** Ergo therapy ☐ speech therapy ☐ physiotherapy ☐
7. **What ist he reason for your today´s visit?**

   _____
8. **Did your child have or does your child still have a sucking habit (pacifer, thumb, …)?**

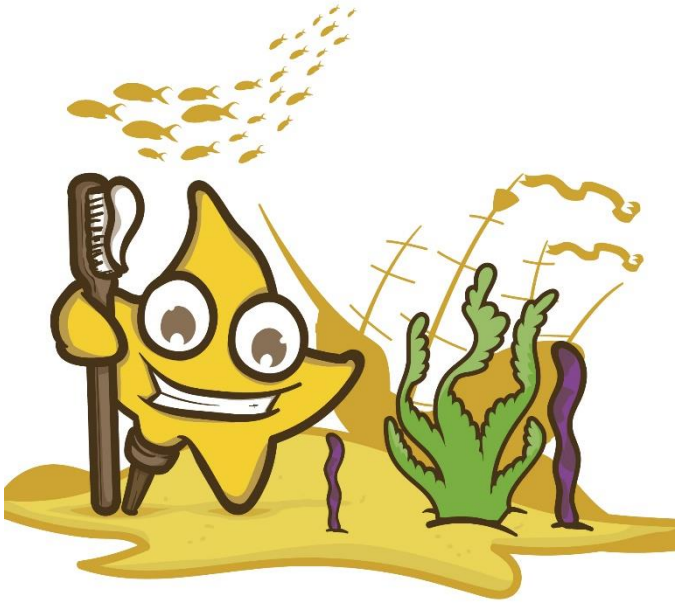
   yes ☐ no ☐
9. How long did you breastfeed your child or give your child the bottle?

   _____
10. **Does your child still use**

    Baby bottles ☐ training cups ☐ sippy cups ☐ sport bottles ☐

    If yes, how often, how long and what? _____
11. **How often does your child brush the teeth? With what? Does your child clean on his/her own?** _____
12. **How frequent does your child eat sugared food daily?** _____
13. **Is your child supplied with fluorids?** yes ☐ no ☐

    If yes, in which form? toothpaste ☐ pills ☐ gels ☐ salt ☐ mineralwater ☐
14. **Do you want to take part in our semiannual recall programm?** yes ☐ no ☐



Please turn →

Dear Parents,

in preparation of a comfortable appointment for your child, we´d like to ask a few questions on habits and favorite activities of your child.

1. **Your child´s nickname?** _____
2. **Is your child going to kindergarten/school?** _____
3. **Has your child been to a dentist before?** yes ☐ no ☐
4. **Is your child afraid oft he dentist?** yes ☐ no ☐

   If yes, what experience did your child make?

   _____
5. **Are you afraid oft he dentist yourself?** yes ☐ no ☐
6. **The world of your child**

   a. favorite activity? _____

   b. favorite animal? _____

   c. favorite (cuddle) toy? _____

   d. favorite book? _____

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!

Thank you very much and have a good time!

_____
date

_____
Signature parents/legal guardian/care giver