Dr. Carola Seekamp
Dr. Sara Nasiri
Fachzahnärztinnen für Kieferorthopädie

Application Form Adults

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 health from unnecessary radiation. In urgent cases, please bring a reference note from your dentist.

_____ _____ _____
patient surname | patient first name | date of birth

_____
address | postal code | city

telephone number

_____ _____ _____
mobile number | home number | office number

_____
email address

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

_____ insured with: ☐ spouse ☐ father ☐ mother
name of insurance

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

_____ _____
profession | employer

_____ _____
Who recommended us to you? | Please provide the name of your family dentist.

Health Questionnaire

What is the reason for your visit?

_____

Do you have:

- Heart or circulatory problems? ☐ 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?_____

Do you take regulary medication? ☐ yes ☐ no

If yes, which one(s)?_____

Have you ever had any unusual reactions to injections, medication or plasters? ☐ yes ☐ no

Do you suffer from diabetes or any other metabolic disorder? ☐ yes ☐ no

Have you been to hospital or have you undergone any other medical treatment? ☐ yes ☐ no

If yes, what was the reason of the medical treatment? _____

Have you been undergoing an operation? ☐ yes ☐ no

If so, give details:_____ When? _____

Have you ever suffered from Hepatitis (inflammation of the liver) ☐ yes ☐ no

Or any serious infectious diseases (HIV, TBC) ☐ yes ☐ no

Please provide the name of your specialist: _____

Do you smoke cigarettes? ☐ yes ☐ no

If yes, how much?_____

Do you snore? ☐ yes ☐ no

Do you grind on your teeth? ☐ yes ☐ no

Do you have a special diet? (vegetarian, vegan, or similar)

If yes, which? _____

Do you take food supplements regularly? ☐ yes ☐ no

If yes, which? _____

Have you ever been to speech therapy? ☐ yes ☐ no

If yes, why _____ When?_____

Do you wear orthopedic shoe inserts? ☐ yes ☐ no

Have you ever had an orthodontic treatment? ☐ yes ☐ no

If yes, why _____ When?_____

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:*_____

Schöne, gesunde Zähne – gut lachen!