Dr. Carola Seekamp
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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 | postal code | city

telephone number

_____ _____ _____
mobile number | home number | office number

_____ _____
email address | school of child

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

_____ insured with: ☐ 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? _____

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:*_____

Schöne, gesunde Zähne – gut lachen!