Dr. Carola Seekamp
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Fachzahnärztinnen für Kieferorthopädie

Application Form Adults / Jaw Pain

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 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 regularly 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 had an accident? ☐ 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

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?_____

Since when do complaints exist and where does the pain mainly occur?

_____

_____

_____

With what intensity would you generally rate your pain?

(1: low; 10: very strong) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Do you have: Intensity

- Pain in the area of the jaw joint? ☐ yes ☐ no ___
- Sometimes pain in the ear area? ☐ yes ☐ no ___
- Frequent Headache? ☐ yes ☐ no ___
- Frequent Neck Pain? ☐ yes ☐ no ___

Do you have any complaints while chewing? ☐ yes ☐ no

Have you ever had difficulties opening your mouth widely? ☐ yes ☐ no

Are your jaw joints making noises? ☐ yes ☐ no

If yes, which one(s)? _____

clicking noise: ☐ right ☐ left grinding noise: ☐ right ☐ left

Have any activities been undertaken recently by your dentist? ☐ yes ☐ no
(New dental care, splint therapy, prescription for physiotherapy, osteopathy or painkillers)

If yes, which? _____

On which side do you mainly chew? ☐ right ☐ left ☐ symmetrical

Do you chew chewing gum? ☐ yes ☐ no If yes: how often? _____

In what position do you sleep at night? ☐ stomach position ☐ back position
☐ on the side: right ☐ on the side: left

Do you do any sport? ☐ yes ☐ no

If yes, which kind of sport? _____

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

If yes, which? _____

How much and what beverages are you drinking on a daily basis?

_____

Do you take food supplements regularly? ☐ yes ☐ no

If yes, which? _____

In your profession are you:

- physically activ? ☐ yes ☐ no
- sitting at the computer/desk? ☐ yes ☐ no
- talking a lot? ☐ yes ☐ no

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:* _____