Dental centre for children and adolescents St. Johannes Hospital

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MEDICAL HISTORY

General informations

Patient: Child Last name: _____ first name: _____ date of birth: _____

Father Last Name: _____ first name: _____ date of birth: _____

Mother Last name: _____ first name: _____ date of birth: _____

Address: postal code: _____ _ city: _____ telephone: _____

Mobile: _____ Street / No. _____

Legal guardian both ( ) Mother ( ) Father ( )

The child is assured with…? _____

Name of the health insurance fund _____ complementary insurance

Pediatrist: _____ Address: _____

Telephone number: _____

General situation

1. Did or does your child suffer from one of the following diseases?

Heart disease	yes/no	metabolic disorder, diabetes	yes/no
Asthma, dyspnea	yes/no	blood clotting dysfunction	yes/no
Allergies	yes/no	liver- or kidney- disease	yes/no
Epilepsy, febrile convulsion	yes/no	learning disability	yes/no
Genetic disease	yes/no	infectious disease, HIV, hepatitis	yes/no

Does your child miss any vaccinations?	Yes/no
Did any difficulties occur at your child's birth?	Yes/no
Was your child ever hospitalized?	Yes/no
Does your child take any pharmaceuticals?	Yes/no

Tooth-mouth-situation

What is the reason for today's visit? _____

Did your child attend any dentist before? Yes/no Dentist's name _____

Does your child suffer from toothache?	Yes/no
Did your child ever have a negative experience at the dentist?	Yes/no
Did your child ever have an accident concerning head or mouth?	Yes/no
Is your child under speech therapy or orthodontic treatment?	Yes/no

Which are your child's hobbies? _____

Who may we thank that you visit our practice? _____

I confirm that I made all information to the best of my knowledge and conscience.

Note: If we do not receive the card of the compulsory health fund within 10 days, we reserve the right for a private invoice.

Please understand that we have to charge 75 Euro each half an hour, if you do not cancel booked appointments (according to § 615 BGB).

Bonn, _____ legal guardian: _____