



Patient:

Family name _____ First name _____ Date of birth _____
Postcode _____ Town/city _____
Street/house no. _____ Telephone no. _____
Health insurer / cost carrier _____

Insured with:

Family name _____ First name _____ Date of birth _____
Postcode _____ Town/city _____
Street/house no. _____ Telephone no. _____
Legal guardian? Father Mother Other _____

Reason for today's dental appointment? _____

Has your child ever had a bad experience at the dentist due to: _____

Previous dentist? _____

Describe your child's previous experience of dental treatment. _____

When was the last dental appointment? _____

Has your child ever experienced dental pain? yes no

Has your child ever suffered any injuries to the mouth or jaw area? yes no

Does your child suffer from any of the following

- | | | |
|---|--|--|
| <input type="radio"/> Asthma | <input type="radio"/> Diabetes | <input type="radio"/> Seizures (e.g. epilepsy) |
| <input type="radio"/> Hearing disorder | <input type="radio"/> Spasticity | <input type="radio"/> Thyroid disorder |
| <input type="radio"/> Kidney disorder | <input type="radio"/> Lung disorders | <input type="radio"/> Blood disorder |
| <input type="radio"/> Tuberculosis | <input type="radio"/> Liver disorder / jaundice | <input type="radio"/> Rheumatism / rheumatic fever |
| <input type="radio"/> Nerve disorder | <input type="radio"/> Gastro-intestinal disease | <input type="radio"/> Immune deficiency (AIDS) |
| <input type="radio"/> Mental disability | <input type="radio"/> Delayed mental development | <input type="radio"/> Learning disability |

Does your child suffer, or has your child ever suffered from a heart disorder? yes no

Congenital or acquired heart disorder Heart surgery Other information: _____

Does your child suffer from any other illnesses/disorders? yes no

If so, please specify _____

Does your child suffer from any allergies? yes no

If so, please specify _____

Does your child take any medication? yes no

If so, please specify _____

Does your child breathe through his/her mouth? yes no

Parents' medical history:

Do you have any allergies that you are aware of? yes no

If so, please specify _____

Are you prone to any of the following?	Father:	Mother:
Cavities?	<input type="radio"/> yes <input type="radio"/> no	<input type="radio"/> yes <input type="radio"/> no
Tartar?	<input type="radio"/> yes <input type="radio"/> no	<input type="radio"/> yes <input type="radio"/> no
Bleeding gums?	<input type="radio"/> yes <input type="radio"/> no	<input type="radio"/> yes <input type="radio"/> no
Fear of the dentist?	<input type="radio"/> yes <input type="radio"/> no	<input type="radio"/> yes <input type="radio"/> no

Your child's eating habits:

- Does your child have a sweet tooth? yes no
- If so, how often does he/she eat sweets/candies? Seldom Once a day Several times a day
- What does your child have for breakfast?
- To drink: Tea / coffee with sugar Tea / coffee without sugar Milk Drinking chocolate
 Fruit juice Other _____
- To eat: Bread Butter Jam or marmalade Chocolate spread Cheese Cold meat
 Muesli Cornflakes Fruit Sweets Other: _____
- What does your child have for lunch? (Name a few everyday examples) _____
- _____
- What snacks does your child eat between meals? Cake Sweets Crisps, pretzel sticks Sandwiches Fruit
- What does your child have for his/her evening meal? (Name a few everyday examples) _____
- _____
- What does your child drink during the day? Tap water / mineral water Sugared fizzy drinks Tea Milk
 Drinking chocolate Fruit juice Coca Cola Other: _____

Dental hygiene

- Are the child's teeth brushed: By the child him/herself? With the help of a parent? By a parent?
- When are the child's teeth brushed? Before breakfast After breakfast After lunch
 Immediately after the evening meal Before going to bed
- What dental hygiene products are used? Manual toothbrush Electric toothbrush Oral water jet
 Dental floss Dental sticks Interdental brush
- Toothpaste: Brand: _____ With fluoride Without fluoride

Extra fluoride:

- Do you give or have you ever given your child "D-Fluoretten" tablets? yes no
- Over what period of time? _____
- Zymafluor? yes no
- Does the child use fluoride gel (e.g. Elmex Gelee)? yes no When, how often? _____
- Does the child use a fluoridated mouthwash? When, how often? _____
- Fluoridation by the dentist? yes no
- Do you use fluoridated salt at home? yes no

Drinking behaviour in infants and preschool children

- How long was your child breastfed? _____
- How long did your child drink from a bottle? _____
- Does your child still drink from a feeding bottle? yes no
- Water Fizzy drinks Fruit juice Sweetened tea Unsweetened tea Sweetened fruit tea
 Unsweetened fruit tea
- Does your child drink out of a cup? yes no
- Water Fizzy drinks Fruit juice Sweetened tea Unsweetened tea Sweetened fruit tea
 Unsweetened fruit tea Milk Drinking chocolate

Date _____ Signature _____

Thank you for your cooperation! Please notify us immediately of any changes to the above-stated information.