DIE KIEFERORTHOPÄDEN
BOCKENHEIM

Dear parents, dear patient,

Thank you for your interest in an orthodontic treatment in our practice.

We would kindly ask you to complete the following pages concerning the medical history of yourself or your child and return the form as soon as possible.

Our postal address is:
Fachpraxis für Kieferorthopädie
Dr. Ruben Lipphardt &
Dr. Anja Gutmark
Kurfürstenstrasse 14
60486 Frankfurt am Main

Via mail: **info@die-Kieferorthopaeden-Bockenheim.de**
Via Fax: **069- 900 198 29**

Upon return of the completed document, we will contact you in order to arrange a suitable appointment.

Referral Information:

Who recommended us?

____

Preferred Contact Details:
□ by phone, your contact number:

____

or
□ by email, your email address:

____

Thank you!

Sincerely,

Praxis
Dr. R.Lipphardt &
Dr. A. Gutmark

Patient Information:

Last Name: ____

First Name: ____ □ **Male** □ **Female**

Date of Birth: ____

Place of Birth: ____

Home Address:

Street Name and House Number: ____

Postal Code and City: ____

Contact details:

Does your child own a mobile/cell phone?

□ **No**
□ **Yes**, the number is: ____

Is your child currently in orthodontic treatment?
□ **Yes**
□ **No**

Please state your child's current dentist:

Name / Place: ____

Please state your child's health insurance company:

Name: ____

By which member is your child covered in the health insurance?

□ **By father**
□ **By mother**
□ **My child is independently covered**

In the case of divorced or separated parents, custody of the child is held by…

□ **Mother only**
□ **Father only**
□ **Both Parents**

Parental Information

Father

Academic titles: □ Dr. □ Prof. □ Other: ____

Last Name: ____

First Name: ____

Date of Birth: ____

Home Address (if other than stated above) and Further Details:

Street Name and House Number: ____

Postal Code and City: ____

Phone: ____

Mobile / Cell: ____

Email: ____

Mother

Academic titles: □ Dr. □ Prof. □ Other: ____

Last Name: ____

First Name: ____

Date of Birth: ____

Home Address (if other than stated above) and Further Details:

Street Name and House Number: ____

Postal Code and City: ____

Phone: ____

Mobile / Cell: ____

Email: ____

Medical History Details (all personal details will be treated discreetly - please also update us of any recent medical changes as soon as possible)

Did or does your child have any of the following sicknesses?

☐ Asthma
☐ Diabetes
☐ Rheuma
☐ Osteoporosis
☐ Blood Disease (Leukemia)
☐ Blood Coagulation Disorder
☐ AIDS or HIV-Infection
☐ Tuberculosis
☐ Liver Disease
☐ Hepatitis Type A/B/C
☐ Epilepsy (Seizure Disorder)
☐ Thyroid Disorder, please specify: ______________________________
Since when? ____________

☐ **All of above sicknesses: NO**

Allergies:

☐ Allergies, please specify: ______________________________
☐ Allergic reactions to prescription drugs etc., please specify:

☐ **All of above allergies: NO**

Other conditions:

☐ Heart Attack / Stroke
☐ Marcumar
☐ Paralysis
☐ High Blood Pressure
☐ Low Blood Pressure

☐ **All of above conditions: NO**

Does your child have a heart pace maker?

☐ Yes
☐ No

Does your child suffer from a heart problem and needs an operation?

☐ Yes
☐ No

Does your child take medicine on a regular basis?

☐ Yes, please specify: ______________________________
☐ No

Further Details / other sicknesses: ______________________________

Has the head of your child been x-rayed before?

☐ Yes, when? ______________________________

In the following practice (please indicate in order for us to request any relevant x-rays):

____

☐ No, there haven't been any x-rays so far.

Personal Details:

Does your child use insoles in its shoes?
□ Yes, since ____
□ Left
□ Right
□ No not anymore, since ______________________________________
□ No, never has.

Has your child been treated or is currently in treatment by a speech therapist?
□ No
□ Yes

When? ____

Is the treatment finished?
□ Yes
□ No
□ Currently taking a break

Name of your child's speech therapist:

____

During night, does your child sleep with…
□ a closed mouth?
□ an open mouth?

Has your child been treated by an Ear-Nose-and-Throat-Specialist?
□ No
□ Yes, for the following reason: ________________________________

Thank you kindly for your cooperation!

____

Date ***Signature***