

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:

**Kieferorthopädische Fachpraxis
Dr. Anja Gutmark
Dr. Ruben Lipphardt
Kurfürstenstr. 14
60486 Frankfurt**

via email: praxis@drgutmark.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.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**

Which parent should receive the bills?

- Mother**
- Father**

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: _____

Is a longer stay outside of Frankfurt planned?

No

Yes, When? _____

Thank you kindly for your cooperation!

Date

Signature