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DR. MARIE-THERESE BRENNER
Zahnärztin

MEDICAL HISTORY FORM PEDIATRIC DENTISTRY

Child's first and last name:_____Insurance No/Date of Birth:_____

Nickname:_____ Favorite activity:_____

Insured first and last name and title:_____ Insurance No/Date of Birth:_____

Legal guardian: ☐ Father ☐ Mother ☐ other

Address:_____ Postcode_____

Tel. Parents:_____ Email: _____

Krankenkasse:_____ Additional insurance:_____

Billing address if different from above: _____

How did you hear about us?_____

Name and address of pediatrician _____

DENTAL HISTORY:

Reason for visit: _____

Has your child received dental treatment in the past?

☐ yes
(when?)_____
☐ no

What is your child's attitude towards the dentist?

☐ neutral ☐ fearful ☐neg. experience

Does your child suck or has sucked on a finger or pacifier?

☐ yes, until_____
☐ no

Is your child already receiving speech therapy?

☐ yes, at_____
☐ no

Did your child have an accident in the mouth/jaw area ☐ yes ☐ no

Oral hygiene:

What does your child clean with?

☐ Hand toothbrush
☐ Electric toothbrush
☐ Interdental brushes / dental floss

Does your child already brush their teeth on their own?

☐ yes ☐ no

Are you brushing your child's teeth?

☐ yes ☐ no

Do you use toothpaste

☐ with fluoride ☐ Without fluoride

Do you use fluoridated table salt?

☐ yes ☐ no

Does/did your child receive fluoride tablets?

☐ yes ☐ no

Nutrition:

My child is still breastfed

☐ yes ☐ no

It was breastfed until the age of _____ months
My child drinks out of

☐ a bottle ☐ a cup

What does your child drink?

_____

How many meals does your child get?

☐ 2-3x ☐ 4-5x ☐more often

Diet:

□ mixed diet □ vegetarian □ vegan

□ gluten-free □ lactose-free

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What does your child eat between meals?

_____

GENERAL MEDICAL INFORMATION:
Please check if applicable the following conditions:

☐ There is no underlying disease

☐ Heart defect, disease or murmur
☐ High blood pressure
☐ Pacemaker
☐ Heart valve replacement
☐ Stroke
☐ Other cardiovascular diseases
☐ Blood clotting disorders
☐ Deficiency of blood / Anemia
☐ Anticoagulant drugs
☐ Thrombosis
☐ Other blood diseases
☐ Lung disease /Asthma
☐ Diabetes
☐ Epilepsy
☐ Glaucoma
☐ Liver disease
☐ Thyroid disease
☐ Kidney disease
☐ Rheumatism / rheumatic fever
☐ Gastrointestinal disease
☐ Hearing disorders
☐ Spasticity or altered muscle tone
☐ Mental delay
☐ Mental disability
☐ Learning disability
☐ ADHD
☐ Tumor disease
☐ Other diseases

_____

☐ Particularities during pregnancy and birth_____

Infectious diseases:

☐ Tuberculosis
☐ Hepatitis A / B / C
☐ AIDS / HIV
☐ other infectious diseases

_____

Childhood diseases:

☐ Measles ☐ Mumps
☐ Rubella ☐ Diphtheria

Is your child vaccinated?

☐ yes ☐ no

If yes, which

☐ Measles ☐ Mumps
☐ Rubella ☐ Diphtheria
☐ Tetanus

Are there any allergies?

☐ Dental materials
☐ Penicillin
☐ Local anesthetics
☐ Latex allergy
☐ Other

which? _____

Does your child take medication regularly?

☐ yes_____
_
☐ no

Has your child ever had surgery?

☐ yes_____
_
☐ no

Has your child had any serious accidents?

☐ yes ☐ no

Has your child ever been hospitalized?

☐ yes ☐ no

Does your child normally

☐ breathe through the nose
☐ breathe through the mouth
☐ have obstructed nasal breathing
☐ snore at night

I understand that I must disclose any change in my child's personal or medical information as soon as possible in order to provide the best possible treatment and care.

Date Signature of legal representative