Patient: Last Name ______ First Name ______ Birth Date ______

German Address: Street: ______ City: ______ Zip Code: ______

Home Phone: ______ Work Phone: ______ e-mail: ______

Insurance Company: ______

German Dentist: ______ Who has recommended us?: ______

Mother of the Patient ______
Only fill in for children under 18

Last Name, First Name ______ Birth Date ______

Address (if different) ______

Phone/ Cell Phone ______

Father of the Patient ______
Only fill in for children under 18

Last Name, First Name ______ Birth Date ______

Address (if different) ______

Phone/ Cell Phone ______

Billing Address : Patient ○ Mother ○ Father ○

General medical History (please mark)

Height Father: ______cm, Height Mother: ______ cm (Only fill in if patient is a child)

Diseases (now or in the past) (Patient)

Diabetes	Yes ○ No ○	Hemophilia	Yes ○ No ○	Heart disease	Yes ○ No ○
Frequent colds	Yes ○ No ○	Angina	Yes ○ No ○	Ear infections	Yes ○ No ○
Hepatitis	Yes ○ No ○	AIDS	Yes ○ No ○	Rheumatism	Yes ○ No ○

Other diseases/ drug ingestion: ______

Allergies

Hay fever	Yes ○ No ○	Asthma	Yes ○ No ○	Drug Allergy	Yes ○ No ○

If so, which?: ______

Other allergies: ______

Accidents (Involving Jaws, Teeth and Face)

Yes ○ No ○ if yes, please describe: ______

Habbits

Did the patient suck the thumb Yes ○ No ○ | another finger? Yes ○ No ○ | up to the age of ______years

Others (like pacifier, etc.)?______

Operations

Tonsils Yes ○ No ○ | Adenoids Yes ○ No ○ | Others? ______

General

Is or was the patient in one of the following treatments?

orthodontically Yes ○ No ○ | speech therapy Yes ○ No ○ | homeopathic Yes ○ No ○

Date: ______

______
Signature