REGISTRATION STATEMENT PRACTICE DRS. MED. DENT. Uwe & Urda Süssenberger

Patient:

Name: **First Name:** **Birth date:**

Zip Code: City: Street:

Telephone: Mobile: E-Mail Address:

Main Insured person:

Name: **First Name:** **Birth date:**

Occupation: Employer:

□ private insurance □ public health insurance

Health insurance / Insurance:

Dentist: Recommended by / Transferred:

Case history:

According to X-ray law, please answer the following questions (please tick):

Has the patient been X-rayed before? No □ Yes □

If so, has it been during the last 12 months? No □ Yes □

If yes: which doctor / dentist / hospital? _____

Is there currently a pregnancy? No □ Yes □

When has been the last dentist visit? _____

Has the patient ever been in orthodontic advice / treatment? No □ Yes □

(If yes: where and when?) _____

Have there been siblings in orthodontic treatment? No □ Yes □

Has one of the parents a malocclusion? No □ Yes □

Does the patient have difficulty in chewing? No □ Yes □

Does the patient grind his teeth ? No □ Yes □

Does the patient have frequent headaches? No □ Yes □

Is the patient currently receiving medical treatment No □ Yes □

(If so, why / where?) _____

Is medication regularly taken? No □ Yes □

(If so, which?) _____

Are there any diseases? No □ Yes □

(Rickets, Diabetes, Tuberculosis, Asthma, Epilepsy, Heart disease,

HIV, Jaundice, Bleeding tendency, etc.?) _____

Is there an allergy? No □ Yes □

Have there already been some head/face, mouth or jaw surgery or accidents before? No □ Yes □

(If so, when & what:) _____

Was / is the patient in speech therapy? No □ Yes □

Has the patient been already at an ENT-doctor? No □ Yes □

Have there been special situations during pregnancy / birth? No □ Yes □

Thumb sucking (until when?) No □ Yes □

Pacifier (until when?) No □ Yes □

Mouth breathing (at night?) No □ Yes □

Miscellaneous _____

Date: Signature: