SIEBER KIEFERORTHOPÄDIE

Pat. Nr. _____

REGISTRATION FORM *Children*

PATIENT

First Name ..... Last Name .....

Date of Birth ..... ☐ Male ☐ Female

Current Address ..... Postcode ..... City .....

Phone..... E-Mail .....

LEGAL REPRESENTATIVES ☐ Mutual ☐ Mother ☐ Father

MOTHER First Name / Last Name .....

Current Address .....

Phone ..... E-Mail .....

Profession / Employer .....

FATHER First Name / Last Name .....

Current Address .....

Phone ..... E-Mail .....

Profession / Employer .....

Insurance ..... Insurance number .....

Dentist ..... When was the last caries control? .....

By whom were you transferred? .....

Did your child ever undergo an orthodontic treatment? ☐ No ☐ Yes

If yes, where? ..... When? .....

Did your child ever have a sucking habit (Thumb, dummy)? ☐ No ☐ Yes

Are you registered by the child and adolescent dental care? ☐ No ☐ Yes

Are you receiving funds through social Assistance? ☐ No ☐ Yes

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HEALTH CARE OF THE PATIENT

Name and Address of the physician .....

Is your child under medical treatment? ☐ No ☐ Yes, why? .....

Is your child taking any medication? ☐ No ☐ Yes, which? .....

Has your child had any severe illness? ☐ No ☐ Yes, which? .....

Has your child ever needed an hospital treatment? ☐ No ☐ Yes, why? .....

Has your child had injuries to the face, mouth or teeth? ☐ No ☐ Yes, which? .....

Do or did your child suffer from:

☐ Allergies ☐ Rheumatism ☐ Hepatitis B,C ☐ HIV, Aids ☐ Blood clotting problems ☐ Asthma

☐ Diabetes ☐ Epilepsy ☐ Heart disease ☐ Drug compatibility ☐ Other.....

All information are subject to the medical confidentiality. The signer agrees that the personal data included in this form could be shared with others related to invoicing / accounting and payment system and that the relevant correspondence could be sent via E-Mail.

Date ..... Signature .....