Health questionnaire of the Family – Dental Practice Isabel Bodenstein

Before starting with the dental treatment we need some information about your health status.
Please fill in the questionnaire.
All answers subject to medical confidentiality of course.

Patient name (child) Surname, Firstname:		Date of birth: Place of birth:	
Insured person Surname, Firstname:		Date of birth: Place of birth	
Address:		Phone:	
Postcode/City: Country:		Mobile:	
E-Mail:			

General questions:

1	What is the reason for your visit?				
	Routine check	Yes		No	
	Pain	Yes		No	
	Trauma	Yes		No	
	Referral from:				
2	Has your child been to the dentist before?	Yes		No	
3	Did your child receive dental treatment yet?	Yes		No	
4	Is your child at day care / kindergarden / school etc. during the day?	Yes		No	
5	Does your child grow up with siblings?	Yes		No	
6	Does your child brush the teeth by itself?	Yes		No	
7	Do you also brush afterwards?	Yes		No	
8	Does your child suck on thumb or soother?	Yes		No	
9	How often does your child snack during the day? - please mark				
	a) none b) 1-2 c) 3-5 d) I don't know				
10	What is your child's main drink? – please mark				
	a) softdrinks b) water c) fruit spritzers d) juices				

Health questions:

11	Does your child suffer from any disease / disability?	Yes		No	
	If so, which?				
12	Is your child currently under medical treatment?	Yes		No	
	If so, by which physician?				
13	Does your child takes medication on a regular basis?	Yes		No	
	If so, which?	Yes		No	
14	Does your child have known allergies / intolerances?	Yes		No	
	If so, which?				
15	Would you like to get a reminder fort he semi-annual check?	Yes		No	
	by SMS				by E-Mail to this address:

I am aware of the fact that in case of late cancellations (24 hours before the appointment) I can be charged for the lost time.
Herewith I confirm the correctness of my information

Signature:		**Date:**	