

Dear patients,  
Welcome to our office! By answering the following questions you enable us to make a careful analysis.  
Your information will of course be treated confidential. Thank you.

**ANAMNESIS FOR CHILDREN AND TEENAGERS**

Patient's last name, first name: .....

Date of Birth: .....  Female  Male

Address: .....

Home phone: ..... Mobile phone: .....

E-mail: .....

Height: ..... Weight: .....

**Last name, first name of the insured person:** .....

Date of Birth: .....  Female  Male

Address: .....

Home phone: ..... E-mail: .....

Mother's height: ..... Profession: .....

Father's height: ..... Profession: .....

**Health insurance of the patient**

Private health insurance: ..... Company name: .....

Compulsory health insurance: ..... Company name: .....

**Name of your attending dentist:** .....

Who may we thank for this referral/recommendation? .....

Has your child already been orthodontically treated?  No  Yes Where? .....

Have any siblings been orthodontically treated?  No  Yes Where? .....

Name of the sibling: .....



**Has your child any of the following diseases?**

- Colds                       Diabetes                       Epilepsy                       Heart diseases  
 Hepatitis                       Blood disorders                       Infections  
 Allergies to?

Other diseases and physical or mental disorders:

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.....

.....

Is your child on any medication?                       No     Yes    Which?

.....

Is there any history of trauma to the head, face or teeth?     No     Yes    When?

.....

Are there any physical or mental disorders?                       No     Yes    Which?

.....

Does your child grind/clench his/her teeth at night?                       No     Yes

.....

Does your child snore?                       No     Yes

.....

Has your child a speech disorder?                       No     Yes

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Has a speech therapy been carried out?                       No     Yes    When?

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Has your child any habits? (e.g. thumb/finger sucking)?     No     Yes    When?                      On what?

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**Why do you want orthodontic treatment?**

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**Please give us sufficient notice if any of the above information changes!**

I give my consent to be reminded of appointments by e-mail or text message. I affirm the completeness and accuracy by my signature:

Berlin, date

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*(Signature of patient, parent or legal guardian)*