# REGISTRATIONFORM

ADRIANA WEISS kieferorthopädie orthodontics

Kieferorthopädische Praxis für Kinder und Erwachsene
Friedberger Landstr. 406
60389 Frankfurt
Telefon 069. 92 397 015
www.kfo-in-frankfurt.de

**Dear Patients,**

welcome to our practice! By answering the following questions you enable us to make a careful analysis. Your information will of course be treated confidentially. Thank you.

**Patient's last name, first name** _____

Date of birth _____ ◦ female ◦ male

Address _____

Home phone _____ Mobile phone _____

E-Mail _____ Profession _____

**Name of the insured parent/guardian/tutor** _____

Date of birth _____ ◦ female ◦ male

Address _____

Profession _____ Mobile phone _____

*If the insured person is not the legal guardian, please complete the following*

**Name of legal guardian** _____

Date of birth _____ ◦ female ◦ male

Secondary Address (if applicable) _____

Profession _____ Mobile phone _____

**Who will receive the invoice/bills?** ◦ parent ◦ legal guardian

**Health insurance of the patient**

◦ private health insurance by _____

◦ compulsory (german statuatory) health insurance by _____

**Name of your attending/family dentist** _____

Whom may we thank for referring you to our office? ◦ Dentist ◦ Family/Friend

◦ Internet ◦ Practice sign

◦ Other _____

Please turn over

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Have you / has your child had any recent X-Rays taken? ○ No ○ Yes *When?* _____

Have you / has your child been orthodontically treated? ○ No ○ Yes *Where?* _____

Has any siblings been orthodontically treated? ○ No ○ Yes *Where?* _____

**Have you / has your child any of the following diseases?**

○ Heart diseases ○ Diabetes ○ Infections (HIV, Hepatitis) ○ TMD

○ Colds/ Flu ○ Epilepsy ○ Blood disorders ○ ADD / ADHD

○ Allergies to _____

○ Surgery *if yes, please explain* _____

Other disease or physical or mental disorders

_____

Are you / is your child on any medications? ○ No ○ Yes *Which?*

_____

Is there a history of trauma to the head, face or teeth? ○ No ○ Yes *When?* _____

Do you / does your child grind/clench his/her teeth at night? ○ No ○ Yes

Do you / does your child snore? ○ No ○ Yes

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

Do you have / has your child any habits? (e.g. thumb/finger sucking) ○ No ○ Yes *Which?*

_____

**Why do you want orthodontic treatment?**

_____

_____

I authorize the performance of diagnostic X-rays of my child if considered necessary or advisable.
I will be informed priorly.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and **that it is my responsibility to inform of any changes in the future**

_____

Date and Signature

Send to practice