DR. MICHAEL MARZELLUS
GOMOLKA
KIEFERORTHOPÄDIE

Dear patient!
Welcome to our Office. Please answer the following questions about your state of health as accurately as possible.
The information collected is subject to medical privacy and data protection laws and will be kept strictly confidential.

KIDS AND TEENS QUESTIONNAIRE

Last name, first name: _____

Date of birth: _____ ☐ female ☐ male ☐ nationality _____

Street, number: _____ Postal code: _____ City: _____

Phone (home): _____ E-mail Address: _____

Insurance information:

☐ Private insurance: _____ ☐ Basic or standard rate? _____

☐ Statutory insurance: _____ ☐ compulsorily insured ☐ voluntarily insured ☐ entitled to aid

Would you like to get a reminder for your appointment? ☐ no ☐ yes

Preferred contact method: ☐ SMS ☐ E-Mail ☐ phone

Last name, first name of the main person insured: _____

Date of birth: _____ ☐ female ☐ male occupation: _____

Address: _____

Phone (home): _____ Cell phone: _____ E-mail Address: _____

Dentist name: _____

How did you hear about our Office? ☐ Dentist ☐ Internet ☐ Ad ☐ Practice signs ☐ Family or Friend

☐ other: _____

Has your child ever received orthodontic treatment? ☐ no ☐ yes where? _____

Have any siblings required orthodontic treatment? ☐ no ☐ yes where? _____

Has your child ever been treated for any of the following? ☐ no ☐ yes where? _____

☐ Heart disease ☐ Diabetes ☐ Infectious diseases (HIV, Hepatitis, Tuberculosis) ☐ Colds

☐ Asthma/Lung diseases ☐ Rheumatism ☐ Epilepsy ☐ Blood disorder ☐ Hepatitis/Liver disease

☐ Thyroid disease ☐ other diseases: _____

Is your child allergic to any medication? ☐ no ☐ yes (nickel, latex) _____

Is your child taking any medication? ☐ no ☐ yes which? _____

Does your child suffer from physical damage/reduced resilience? ☐ no ☐ yes which? _____

Are there problems with his/her health now? ☐ no ☐ yes which? _____

Has your child ever had an injury to teeth, mouth or chin? ☐ no ☐ yes when? _____

Does/did your child grind his/her teeth at night? ☐ no ☐ yes when? _____

Does/did your child receive logopaedic treatment? ☐ no ☐ yes when?/where? _____

Does/did your child have a thumb sucking habit? ☐ no ☐ yes when? _____

The information above is correct and the insurance information is complete. I agree to immediately report any and all changes arising during the entire treatment period.

Stuttgart, _____

(Date / Signature parent or legal guardian if patient is under 18)

clear send