Kompetenzteam für Zahnheilkunde
KONZEPT.KOMPETENZ.QUALITÄT.SERVICE

Dear parents,

It is very important to us, that your child's first dentist appointment is a positive experience. This is why we pay extra attention to your daughter/son. A cautious and child oriented treatment is extremely important to build trust for all future treatments. This questionnaire will help us to get to know your daughter / son better and treat her / him in the best way possible. We therefore kindly ask you to fill out the following form.

PERSONAL INFORMATION

Child: Surname / Name _____ Date of Birth: _____

Mother: Surname / Name _____ Date of Birth: _____

Father: Surname / Name _____ Date of Birth: _____

Address: _____ Postcode/Town: _____

Tel (Home) _____ Tel (Mobile): _____

Legal guardian: o Mother o Father o Both

Health Insurance: _____

O Public Health Insurance □ Membership □ Co-insured / □ with additional insurance □ without additional insurance

O Private Insurance If yes: beihilfeberechtigt O yes O no

Co-insured with the membership of: o Mother o Father

Address (if different to your child's): _____

How did you hear about us? _____

MEDICAL HISTORY

Does your child suffer from any of the following diseases/illnesses?

Infectious disease	o yes	o no	If yes, which?	_____
Cardiac disease	o yes	o no	If yes, which?	_____
Haematopoietic disease	o yes	o no	If yes, which?	_____
Respiratory disease	o yes	o no	If yes, which?	_____
Endocrine/metabolic disease	o yes	o no	If yes, which?	_____
Nervous disease	o yes	o no	If yes, which?	_____
Allergies	o yes	o no	If yes, which?	_____
Other diseases/conditions	o yes	o no	If yes, which?	_____

Is your child immunised against tetanus? o yes o no _____

Is your child taking and medication? o yes o no If yes, which? _____

Surname, Name: _____

Date of Birth: _____

DENTAL HISTORY

Has your child been to a dentist before? o yes o no

If yes, name/address of the dentist: _____

Does your child currently receive orthodontic treatment? o yes o no

If yes, name/address of the dentist: _____

Has your child had any previous dental X-rays? o yes o no If yes, from when? _____

Does your child have a tooth ache? o yes o no

Does your child clench or grind her/his teeth? o yes o no

How often does your child brush her/his teeth? _____

Who brushes the teeth? o child o parents

o child first, parents after

Is your child scared of white gowns, needles, etc.? o yes o no If yes, of what? _____

Has your child had any accidents in the dental area? o yes o no If yes, when? _____

DIETARY HABITS

Does your child use any products containing fluoride? o yes o no If yes, which? _____

Does your child take any drinks to bed? o yes o no If yes, which? _____

Does your child suck on dummies / his/her thumbs? o yes o no If yes, on what? _____

How often does your child have sweets? _____

What does your child drink from? o feeding bottle o sippy cup o cup / mug

To the parents:

Are the parents scared of dentists / dental treatment? o yes o no

_____ _____

Place, Date Signature parent / legal guardian

Here is some more advice on how to make a dentist appointment more pleasant for your child:

Come to the appointment with an open mind. This will give your child a feeling of safety and trust. A dentist appointment is something completely normal.

Don't „pre-comfort" your child. When children hear words like "You don't need to be scared.", "Nothing bad is going to happen.", "It won't hurt.", etc. children subconsciously only hear the words "scared", "bad" and "it hurts". This can cause anxiety in your child.

Announcing post treatment rewards before the appointment can put a lot of pressure on your child. Instead, reassure your child with praise after the appointment. This will help her/him grow from the experience.

Of course, you can come to the dentist's room with your child and be there as a "still observer" throughout the appointment.
If your child is older than 5 years old, reassure her/him that she/he can take this step on her/his own. This will make the whole experience feel more natural for your child. Be patient, if the first dentist appointment doesn't go the way you hoped it would. It's important to us to introduce your child to potential future treatment step by step.

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Datenschutzrechtliche Einwilligungserklärung

für die Verarbeitung personenbezogener Patientendaten
gemäß Art. 6 Abs. 1 Buchst. a), Art. 7 DSGVO

Patient/in:

Name _____

Straße _____

PLZ, Ort _____

Ich stimme hiermit der Speicherung meiner personenbezogenen Daten für folgende Zwecke zu:

- die Verarbeitung von Gesundheitsdaten von Patienten zum Zweck der Erfüllung gesetzlicher Dokumentationspflichten
- die Verarbeitung und Weitergabe (auch telefonisch, per Email oder Fax) von Patientendaten zur Planung und Durchführung von Behandlungen z.B. an Anästhesisten, Chirurgen, Zahntechniker, o. Ä.
- die Verarbeitung von Patientendaten zum Zweck der Erstellung einer Abrechnung
- die Verarbeitung von Patientendaten zur Forderungsdurchsetzung
- die Verarbeitung von Patientendaten im Zusammenhang mit einem Recall–System

Ich bin darauf hingewiesen worden, dass ich diese Zustimmung jederzeit schriftlich oder durch E–Mail an die Praxis widerrufen kann (Art. 7 Abs. 3 DSGVO).

Mir ist bekannt, dass mein jederzeit möglicher Widerruf der Einwilligung die Rechtmäßigkeit der aufgrund der Einwilligung bis zum Widerruf erfolgten Verarbeitung nicht berührt (Art. 7 Abs. 3 Satz 2 DSGVO).

_____ _____

Ort, Datum Unterschrift des Patienten / des gesetzl. Vertreters