32/20 Praxis für Erwachsenen und Kinderzahnheilkunde
Dr. Carola Allihn und Dr. Marcel Allihn
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Dear parents, welcome in our dentist office!

Before we can dedicate our time to your child, our team needs some information.

Its important to answer all questions consciently and inform us about any changes to avoid any possible risks.

All information is subject to the medical confidentiality. Thanks for your cooperation!

Personal data

Child: Name: _____ Surname: _____Date of birth:_____in_____

Mother: Name: _____Surname: _____Date of birth:_____

Profession: _____

Father: Name: _____Surname: _____Date of birth:_____

Profession: _____

Adress: Postal code: _____Place of residence: _____ Tel:_____/_____

Street + Number _____ Tel:_____/_____

Email: _____

Custody Both ☐ Mother ☐ Father ☐ Other ☐

Child is insured by: Mother ☐ Father ☐ Other ☐

Where have you first heard fom us ? (Recommendation, Internet, medical referral)?_____

Reasons for bringing your Child

How can we help you/why did you get a medical referral?

_____

What wishes and /or expectations do you have about the treatment of your child?:

_____

Does your child already have cavities/caries? YES ☐ NO ☐

Is your child experiencing tooth ache? YES ☐ NO ☐

Is your Child currently taking any pain killers/antibiotics because of their teeth ? YES ☐ NO ☐

General questions

Have there been Incidences /particularities regarding the pregnancy/ birth or time after birth? YES ☐ NO ☐
If yes, what kind? _____

Is your child currently in medical treatment? YES ☐ NO ☐
Name of doctor: _____

Wich medications is your child currently taking ? _____
NONE ☐

Does your child suffer from allergies, asthma or hay fever? YES ☐ NO ☐

Has there been any reaction to any medication before? YES ☐ NO ☐

Does your child suffer from heart disease? Does it own a record pass? YES ☐ NO ☐

_____

Has your child experienced fever cramps/seizures? YES ☐ NO ☐

Has your child diabetes or thyroid disease ? YES ☐ NO ☐

Has your child a bleeding tendency or blood clotting disorder? YES ☐ NO ☐

Does is suffer from infectious diseases like hepatitis or HIV? YES ☐ NO ☐

Does it suffer from genetic diseases? YES ☐ NO ☐

Other illnesses: _____ YES☐ NO ☐

Name of pediatrician: _____

Kids World

How your child likes to be called: _____

favorite- animal:_____ - toy:_____ - sport: _____ - food: _____

Has it visited the dentist before? YES ☐ NO ☐

Has your child made any negative experiences at the dentist? YES ☐ NO ☐

Has there been an accident in the facial area? YES ☐ NO ☐

Is your child in speech therapy or orthodontic treatment? YES ☐ NO ☐

Has somebody already made x-rays of your childs teeth ? YES ☐ NO ☐

Caries risk in the family

Do any siblings have caries? YES ☐ NO ☐

Did any siblings recieve dental treatment under anastheisa? YES ☐ NO ☐

Are you scared of the dentist? Mother YES ☐ NO ☐ Father YES ☐ NO ☐

How is your dental health? Do you regulary go to the dentist for check ups? YES ☐ NO ☐

Do you have any problems with caries YES ☐ NO ☐ gums/periodontitis? YES ☐ NO ☐

Dental care

How often do you brush the teeth of you child/does the child brush its teeth? Once a day ☐ 2-3 times a day ☐

Who brushes the teeth?_____

Wich tools do you use for brushing the teeth of your child? ☐ manual toothbrush ☐ electric toothbrush

Is brushing the kids teeth easy for you? YES ☐ NO ☐

Are there any difficulties? YES ☐ NO ☐

If yes, wich are they? _____

Are you intresested in partaking our preventive program **STARKE ZÄHNE – *gesunde Zähne kannst Du lernen***?

YES ☐ NO ☐

Fluorides

Wich toothpaste is your child using ?

☐ toothpaste without flourides ☐ toothpaste containing 500ppm fluoride

☐ toothpaste containing 1000ppm fuoride ☐ toothpaste for adults contaning 1400ppm fluoride

Do you give flouride tablets to your child? YES ☐ NO ☐

Do you use salt containing flourides for cooking? YES ☐ NO ☐

Habits and nutrition

What does your child drink?

☐ Milk ☐ Water ☐ Tea with/without sugar ☐ Juice/Spritzers ☐ Ice tea, Cola, Lemonade, CapriSun, Cacao

Does your child drink anything during the night? YES ☐ NO ☐ Wich bevarage: _____

Questions for babies:

Does your child suck on the ☐ thumb ☐ pacifier?

Did you breastfeed your child? YES ☐ NO ☐

If yes for how long? _____ months Do you still breastfeed during the night YES ☐ NO ☐

Genral information and agreement

Do you want to get reminded of the regulalry check ups (recallsystem)?

☐ Email ☐ Telephone call ☐ SMS ☐ No

Appointments Appointments...

For your appointment we reserve time and our team, wich prepares everything just for you. If you dont come in for your appointment we have to throw many single use items in the trash and purify all of our intruments once again.

If you are unable to come in for your appointment, we'd like to ask you to cancel your appointment 24 hours prior.

If you miss your appoinment or arrive very late we would have to charge a fee in the amount of 60 € (§670BGB). This is also regarding the professional tooth cleaning.

I verify the accuracy of my data. I've read and agree to the information regarding the data protection, recall system and regulations for keeping my appointment.

Lübeck, the _____ Signature: _____

(legal guardian)

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Agreement for dental local anesthesia

The dental anesthsia is used for local pain elemination in the tooth, mouth and jaw area. Using local anesthesia makes it possible to execute treatments almost without any pain. Although the local dental anesthesia is a safe procedure, its possible that certain side effects or intolerances may appaer. Theres a slight chance that the following complications may occur:

Uncommonly, when using block anesthesia, there can be an irritation of the nerve fibers. This can very rarely result in temporary or continious sensation disturbance (complicationrate 0,01%). This is mostly regarding the lower jaw, also regarding the selective tounge and lip area.

When using local anesthesia during dental treatment there can be a slight impariment regarding the reaction- and concentration ability. Your child should not activly partake in any traffic.

While the dental anesthesia is still working, it's best for your child not to eat or drink anything. Its possible that your child might get (freeze-) burns or bite injuries.

I /We have read and understood the clarification. The dental treatment and the following risks and other possibilities have been explained to me/us. All my/our questions have been answered to the full extent. I/We are agreeing that our child receives tretment under local anasthsia.

Lübeck, the_____ Signature: _____
(Erziehungsberechtigte/r)

Agreement for dental tretment of minors
(to be filled in from the dentist)

Is the patient underage, an agreement for treatment of the legal guardian is mandatory.

Name of the Child: _____ Date of birth _____

Agreement for dental diagnosis and treatment

- ☐ digital x-rays
- ☐ composite/cementfillings
- ☐ other:_____
- ☐ Tooth fillings
- ☐ pädiatric crowns for children
- ☐ tooth-extractions
- ☐ alternative caries therapy

Lübeck, the_____ Signiture: _____
(legal guardian)