kidssmile ;-)

Surname _____ First name _____ Date of birth_____

Main insured _____ Date of birth _____

Address _____

Email _____

Telephone _____ mobile _____

Insurance company and number_____

Legal guardian: □ father □ mother □ _____

Paediatrician_____ Dentist _____

Reason for the visit

□ check-up □ pain □ accident □_____

Date of last dental visit? _____

Has your child ever had dental pain? □ yes □ no

Has your child had an accident in the oral/maxillofacial area? □ yes □ no

Are there any allergies? □ yes □ no

If yes, to what? _____

Tick the relevant box to indicate whether the following apply to your child

□ Epilepsy □ Asthma □ Blood disease

□ Heart problems □ HIV/AIDS □ Liver disease

□ Kidney disease □ Diabetes □ _____

Are there any developmental delays? Which? _____

Who brushes the teeth of the child? □ parent □ child

How often the teeth are brushed? □ sometimes □ 1 times a day □ 2-3 times a day.

How are the teeth cleaned? □ manual toothbrush □ electric toothbrush

Which toothpaste is used? □ < 6 years □ > 6 years □ fluoride-free

Children after 6: Do they use Elmex Gelee? □ yes □ no □_____

Are you giving fluoride tablets? □ yes □ no □_____

Are you using fluoridated salt? □ yes □ no □_____

Does your child have following habits? □ Pacifier □ Thumb sucking

What is your child drinking? Out of what? _____

What is your child drinking/eating during the night- after brushing? _____

We require you to give us at least 24 hours 'notice should you need to cancel an appointment, if not we will invoice you for the lost time. We appreciate your understanding in this regard.

To the best of my knowledge, the information given herein are correct.

_____ _____

Date Signature of parent/guardian