DR. HUBER
KIEFERORTHOPÄDIE

REGISTRATION & MEDICAL HISTORY FORM

Dear patients,
Welcome to the DR. HUBER ORTHODONTIC CLINIC!

To enable us to provide you with comprehensive and individual consultation, please take a moment to complete your personal details. This information is necessary as a basis for constructive cooperation as well as to ensure successful orthodontic treatment. It is subject to medical confidentiality in accordance with Art. 203 of the German Penal Code (StGB) and will be treated strictly in accordance with the relevant data protection laws.

PERSONAL INFORMATION

PATIENT'S CONTCT DETAILS

☐ M ☐ F

Surname | given Name

Title

House | Street Number

Date of birth

Post code | Town/City

E-mail

Phone number (home)

Phone number (mobile)

Phone number (work)

CONTACT DETAILS OF THE MAIN INSURANCE HOLDER

If the patient is not the main health insurance holder, please provide the following details:

Surname | given Name

Titel

House | Street Number

Date of birth

Post code | Town/City

E-mail

Phone number (home)

Phone number (mobile)

Phone number (work)

CONTACT DETAILS OF THE GUARDIANS*

If the main health insurace policy holder is not the guardian, please provide the following details:

Surname | given Name

Titel

House | Street Number

Date of birth

Post code | Town/City

E-mail

Phone number (home)

Phone number (mobile)

Phone number (work)

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TYPE OF INSURANCE | INVOICE RECIPIENT

☐ Insured under a statutory insurace plan
- ☐ on a compulsory
- ☐ on a voluntary basis

Name of the health insurance company

☐ Private health insurance
- ☐ Basic private insurance
- ☐ Private comprehensive insurance
- ☐ Eligible for assistance

Name oft the assistance | insurance

☐ Supplementary insurance for orthodontics

☐ Send invoice to:
- ☐ Patient | Main policy holder
- ☐ Parent | Guardian
- ☐ Any other person :

FOR PARENTS WITH STATUTORY HEALTH INSURANCE
Your health insurance requires that you bring your insurance card to every appointment at the surgery. If you do not present our health insurence card at least once per quarter, we are required by the health insurance company to charge you for the current quarter.

CONTACT DETAILS OF THE DOCTOR | DENTIST

GP's name | Adress (if known) | Phone number (if known)

Dentist's name | Adress (if known) | Phone number (if known)

I agree that my dentist should be kept informed about the planned orthodontic treatment an the progred of treatment ☐ Yes ☐ No

QUESTIONS ABOUT X-RAY TREATMENT

Have you already had X-Rays taken of your teeth and | or your head? ☐ Yes ☐ No

When were the X-Ray performed and by whom?

Do you | does your child have an X-Ray registration card? ☐ Yes ☐ No

Is the patient pregnant? ☐ Yes ☐ No

HEALTH – RELATED QUESTIONS ABOUT ORTHODONTIC TREATMENT

Has the patient had any accidents affecting their head | face? ☐ Yes ☐ No

If so, please provide details?

Were the teeth or jaws affected? ☐ Yes ☐ No

Do you | does your child often catch a cold? ☐ Yes ☐ No

are there any problems by breathing through the mouth or nose? ☐ Yes ☐ No

Is the patient prone to sucking their thumbs | fingers, or were they in the past? ☐ Yes ☐ No

If so, until when?

Does the patient have any problems with their speech development (lisping, stuttering)? ☐ Yes ☐ No

Is the patient receiving speech therapie | counselling or have they in the past? ☐ Yes ☐ No

If so, when?

Does the patient have any problems in the region madibular joint (clicking, rubbing, pain)? ☐ Yes ☐ No

Is the patient prone to cleaning or grinding of the teeth, or were they in the past? ☐ Yes ☐ No

Does the patient suffer from frequent headaches, pain in the facial area or when chewing? ☐ Yes ☐ No

If so, please provide details?

Do you | does your child snore? ☐ Yes ☐ No

PLEASE REFER TO THE FOLLOWING SHEET

Do you | does your child sleep with your | their mouth open? ☐ Yes ☐ No

Is the patient prone to clenching pencils, nail biting, lip biting or toungue thrusting or has this occured in the past? ☐ Yes ☐ No

If so, until when? _____

Have you | has your child ever had orthodontic consultation? ☐ Yes ☐ No

If so, who was it performed by? _____

Is there documenation?? ☐ Yes ☐ No

If so, please provite details _____

Are you | is your child already receiving an orthodontic treatment or have you | has your child received such treatment in the past or has such treatment been planned? ☐ Yes ☐ No

If so, who was it performed by? _____

Was the treatment completed successfully? ☐ Yes ☐ No

Do you | does your child play a wind instrument? ☐ Yes ☐ No

Have any other family members undergone orthodontic treatment? ☐ Yes ☐ No

Was the teatment | consulation conducted by an ear, nose and throat specialist? ☐ Yes ☐ No

If so, what was done? ☐ Tonsillectomy ☐ Adenoidectomy ☐ Other _____

GERNERAL HEALTH - RELATED QUESTIONS

Does the patient suffer from any general medical conditions (e.g. cardiovascular disease, coagulation disorder, diabetes, etc.) or infectious diseases (e.g. hepatitis, tuberkulosis, hospital bugs such as MRSA, Creutzfeldt-Jakob disease, HIV | AIDS, etc.)? ☐ Yes ☐ No

If so, please provide details. _____

Do you | does your child take regular medication? ☐ Yes ☐ No

If so, which medication and for what? _____

Does the patient suffer form any allergies, intolerances or is there any suspected hypersensivity? ☐ Yes ☐ No

If so, please provide details. _____

Do you | does your child have an allergy passport? ☐ Yes ☐ No

Is the patient currently receiving physiotherapy or undergoing osteopathic treatment? ☐ Yes ☐ No

Does the patient suffer from any other diseases, physical or mental restrictions? ☐ Yes ☐ No

If so, please provide details. _____

WHAT BENEFIT DO YOU EXPECT FROM THE ORTHODONTIC TREATMENT?

☐ Straight teeth
☐ Better chewing ability
☐ Better pronunciation
☐ Elimination of pain
☐ Improved facial aesthetics
☐ Prevention (with respect tot he tooth)

What are you most unhappy about with the malpositioning of your | your child‘s teeth and jaw? _____

HOW DID YOU HEAR ABOUT OUR CLINIC

☐ Family, friends, acquaintances
☐ Dentist _____
☐ Business directory | yellow pages
☐ Advertisement (newspaper, etc.)
☐ Google, Web
☐ Doctor | health portal (e.g. Jameda)
☐ Outdoor advertising (billboards, etc.)
☐ Other _____

REMINDER SERVICE

Please remind me about appointments by ☐ E-mail ☐ SMS ☐ No reminder necessary

PLEASE TURN THE PAGE

X – RAY CONSENT FORM

☐ I here by authorise the performance of X-ray required a spart of orthodontic treatment on me | my child.

☐ I here by release Dr. Lothar Linus Huber from docotr – patient confidentiality obligatore the X-ray images produced and agree to these X-rayss being sent to referring dentists by e-mail or diagnostic or therapertic purposes.

By signing this document, I confirm that the information provided about me | my child is correct and complete and I expressly agree tot he storage of my child's personal data. In case of changes about my personal data, I agree to immediately inform.

Organisational note:

To keep waiting times to a minimum, we run an appintment-base clinic. Each appointment is reserved especially for you | your child, because high-quality workmanship takes times. ☺ We therefore ask you to give us at least a 24 hours' notice if you need to cancel.

*If the consent is given by parents for their child, consent should always be given by both parents. If only one parent signs, they simultaneously declare with their signature that they have sole custody of the child or that they have been authorised by the other parent to grant this consent on their behalf.

Place | Date

Signature oft he guardian

Thank you completing the form!

From the whole team at the DR. HUBER ORTHODONTIC SURGERY!

DR. LOTHAR LINUS HUBER
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