KFO 5 SEEN
Kieferorthopädie Starnberg

Dr. Schamiem Stumpfe
Kreuzstraße 22
82319 Starnberg
Tel.: 08151/7503407
info@kfo5seen.de

Welcome to our orthodontic office!

In order to treat you or your child individually and safely, we need some information. As diseases of all kinds can affect the treatment, please fill it out precisely.

Of course, your information is subject to medical confidentiality and data protection.

We need your health insurance card every time you visit the practice. We have to point out that we consider you as a private patient and you will receive an invoice according to the private fee schedule (GOZ), unless we have your health insurance card within 14 days.

We will be happy to help you if you have any questions, or if you need help filling out the form

Name (Patient)		Name (insured person)	
Surname (Patient)	Date of Birth	Surname (insured person)	Date of birth
Street Address, No		Profession	
Zip, City			
Phone number			
Dentist			
Insurance Company Name			

Please answer the following questions regarding your state of health:

		Yes	No
I. General medical history			
1.	Why are you coming to our practice? reason:		
2.	Did the patient had a previous orthodontic treatment? if yes, with whom? Dr. in	☐	☐
3.	Does the patient has a current orthodontic treatment? if yes, with whom? Dr. in	☐	☐
4.	Is the treatment completed? if no, what ist he reason?	☐	☐
5.	How did you find out about our practice?		
II. Family medical history			
6.	Has or had a parent/sibling bite irregularities? if yes, who?	☐	☐
7.	Are there any hypodontia (less teeth) cases in the family? if yes, which teeth?	☐	☐
III. Patient medical history			
8.	Does the patient suffer from any of the diseases mentioned?	☐	☐
	☐ rickets ☐ diabetes ☐ hepatitis/HIV ☐ heart disease ☐ epilepsia ☐ coagulation disorders ☐ asthma ☐ allergic asthma since when		
9.	Does or did the patient take any medication? if yes, which one?	☐	☐

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		Yes	No
III. Patient medical history			
10.	Does the patient has problems with nasal breathing?	☐	☐
	☐ mouth breathing ☐ snoring since when		
11.	Does the patient have an allergy or hay fever?	☐	☐
	if yes, against what?		
12.	Does or did the patient have a speech defect?	☐	☐
	if yes, when how long? months / years		
	if yes, which defect?		
	Did the patient have speech therapy?	☐	☐
13.	Did the patient have an accident with consequences fort he head and neck area?	☐	☐
	if yes, when?		
	with tooth injury?	☐	☐
	with tooth loss?	☐	☐
	with broken jaw?	☐	☐
14.	Does the patient grind with the teeth?	☐	☐
15.	Are there any problems with the temporomandibular joint?	☐	☐

Starnberg, 31.07.2023

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Patient/Parents signature (Legal Guardian)