BRAND ORTHODONTICS
KIEFERORTHOPÄDIE AM BRAND

MEDICAL PREHISTORY FORM - ANAMNESIS

Dear Ladies and Gentlemen patients, dear parents,
welcome to my office

We, the team of BRAND ORTHODONTICS, would like to make your stay at our place as pleasant as possible. In order to create your personal ambulatory card / the ambulatory card of your child and in the interest of treatment without complications we need some data about you/your child.
Please put down the complete and correct answers to the following questions. Should you have any questions, do not hesitate to ask our team at the reception office. Under § 203 Penal Procedure Code all data are protected under the medical secrecy

PATIENT DATA

Surname, given name _____ Date of birth _____

Street, number _____ P.O.B., _____

Settlement /Telephone _____ Mobile phone _____ E-Mail _____

Health insurance _____

Member of (in the case no own insurance is available) _____ Date of birth _____

Profession, employer _____

IN THE CASE OF MINOR PATIENTS*

Data about the person accompanying the minor patient

Surname, given name _____ Date of birth _____

Street, number _____ P.O.B., Settlement _____

Phone _____ Mobile phone _____ Email _____

Is supplementary health insurance available for orthodontic services? ☐ Yes ☐ No
Are there grounds for providing assistance? ☐ Yes ☐ No

Your general practitioner / The general practitioner of your child _____

GENERAL ANAMNESIS

Were x-ray photos recently taken? ☐ Yes ☐ No
If yes, when and where: _____

Was orthodontic consulting/orthodontic treatment rendered? ☐ Yes ☐ No
If yes, when and where: _____

Were any documents issued? ☐ Yes ☐ No
If yes, what were they: _____

Have other family members been subjected to orthodontic treatment? ☐ Yes ☐ No
What is that in the teeth/jaw deformation that bothers you the most? _____

Does he/she play a brass instrument? ☐ Yes ☐ No
If yes, what is it: _____

Turn the page please!

Has he/she been sucking his/her thumb, now or in the past? ☐ Yes ☐ No

Has he/she been using soother at present or in the past? ☐ Yes ☐ No

Has he/she been biting his/her nails? ☐ Yes ☐ No

Has he/she been grinding his/her teeth or clenching his/her bite? ☐ Yes ☐ No

Were the teeth or jaw damaged during an accident? ☐ Yes ☐ No

Are there/were there complaints related to temporomandibular joint, the masticatory muscles or frequent headaches? ☐ Yes ☐ No

Has he/she rheumatoid disease? ☐ Yes ☐ No

Is breathing inhibited through the nose or the mouth? ☐ Yes ☐ No

Were the tonsils or any polyps eliminated? ☐ Yes ☐ No

Is he/she currently undergoing general medical treatment, or naturopathic physiotherapy? ☐ Yes ☐ No

If yes, of what type?

Does he/she suffer from some of the following diseases:

Circulatory disorders	☐ Yes	☐ No	HIV / AIDS	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Blood clotting disorders	☐ Yes	☐ No	Others	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	If yes, what:		
Intrahospital infection (for example MPCA,)	☐ Yes	☐ No			
Creutzfeldt–Jakob disease / versions	☐ Yes	☐ No			

Do you have any allergies? ☐ Yes ☐ No

If yes, what:

Do you take medicines regularly? Yes ☐ No ☐

If yes, which:

Are you pregnant? ☐ Yes ☐ No If yes, in which month? _____

How did you get to know about us? / Who recommended us?

We would provide you the special service of sending automatic text message to remind you of the time of your next visit some 24 hours in advance. Would you like to take advantage of that service? Yes ☐ No ☐

Do you consent to sending you information about our centre and events? Yes ☐ No ☐

If yes, in what way? ☐ Via post ☐ Email

Note on the organization manner: the arranged dates are booked for you. Please avoid short-term cancellation and suspension. Please take into consideration that the appointments not cancelled at least 24 hours in advance should be invoiced to you in the capacity of physical person. We have the right to invoice this way the members of mandatory health insurance under the Ordinance of the amount of dentists' fees (GOZ).

After laying my signature I confirm the completeness and precision of my abovementioned personal data and provide my consent to having my personal data/the personal data of my child stored. These would be used only for my treatment and for communications with my dentist. Additionally, I consent to having the necessary X-ray tests of my child performed, being a part of the orthodontic treatment.

* If the parents provide their consent for their child, the following rule is effective: In principle, both parents should provide their consent. If one parent lays his/her signature individually, at the same time he/she declares that he/she has the right to individual custody or that he/she was authorized by the other parent to declare consent on his/her behalf.

Signature laid by the patient/ the companion correspondingly

Settlement / Date

We would like to warmly thank you for spending your time in answering our questions! If your data undergo changes, please inform us in timely manner.

Your medical team

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