Dr. Astrid Weller-Bergmann
Fachzahnärztin für Kieferorthopädie
Beethovenallee 58
53173 Bonn

Telefon: 0228 – 184 73 74
Fax: 0228 – 184 73 75

Patient Surname

Insured Surname

Patient Name Birthdate

Insured Name Insured Birthdate

Home Address: Street

Employer

Postcode, City

Surname Spouse Spouse Birthdate

Home Telephone

Work Telephone

Email Address

Dentist

Siblings in orthodontic treatment

Insurance or Health Fund
(please also list location and branch e.g. DAK Bonn, TK Nordrhein)

Nationality

Are you: ☐ publicly insured ☐ privately insured ☐ private payer

☐ with "Beihilfe" ☐ "zusatzversichert" ☐ "Postbeamtenkasse"

☐ **B**eihilfestelle des Bundes ☐ Beihilfestelle des Landes

Welcome to our Practice!

Prior to sitting with you to discuss your orthodontic wishes and questions, we require some personal details as well as medical information about the patient. This is important to determine the most suitable and risk-free treatment. All information is subject to medical confidentiality. Thank you for answering the questions below.

You were sent to us by _____

You first heard about us from _____

You found us in the Yellow Pages ☐ in Google ☐ in our website ☐ elsewhere? _____

	Yes	**No**
Is the patient currently in orthodontic treatment?	☐	☐
Has the patient been in orthodontic treatment in the past? -if yes, Dr. _____, in _____	☐	☐
Has an orthodontic consultation occurred during the past year?	☐	☐
Are recent x-rays (last half year) of the patient's jaws and teeth available?	☐	☐
Have any parent or siblings had dental irregularities (aplasia)?	☐	☐

	Yes	No
Are there cases of missing teeth in the greater family?	☐	☐
Has the patient suffered from any of the following illnesses?	☐	☐

- if yes, which: ☐ rickets ☐ diabetes ☐ hepatitis A/B/C ☐ heart disease

☐ epilepsy ☐ tuberculosis ☐ HIV ☐ other: _____

Is the patient consuming any medication on a regular basis, if yes, which? _____	☐	☐

_____

Does the patient have any spinal issues?	☐	☐
Does the patient have any TMJ complaints?	☐	☐
Does the patient have any of the following breathing problems?	☐	☐

☐ asthma ☐ allergenic asthma since: _____

☐ frequent colds since: _____

☐ breathing through mouth ☐ snoring since: _____

Does the patient have an allergy or hay fever? If yes, against what? _____	☐	☐
Has the patient had any ENT (Ears, Nose Throat) operations?	☐	☐

☐ tonsils (ectomy) when: _____

☐ adenoids (ectomy) when: _____

☐ nasal septum correction when: _____

☐ paracentesis when: _____

Any thumb sucking or similar habits?	☐	☐

☐ finger ca. until _____ years ☐ pacifier ca. until _____ years

☐ other: _____ ca. until _____ years

By children: is the patient an early ☐ or late teether? ☐

Any lip or tongue habits?	☐	☐

☐ lip biting ☐ lip sucking ☐ lip licking

☐ nail biting ☐ pencil chewing ☐ other: _____

Does the patient have any speech problems or tongue dysfunction?	☐	☐

- if yes, what kind of dysfunction _____

- has a speech therapy treatment occurred?	☐	☐
Has the patient had any accidents affecting their head or neck areas?	☐	☐

- if yes, when? _____ any dental injuries? _____

- with loss of teeth or broken jaws? _____

	Yes	No
Does the patient grind their teeth?	☐	☐
Does the patient wear a tooth guard?	☐	☐
Have the wisdom teeth been removed?	☐	☐

Which sports does the patient practice? _____

Which musical instruments does the patient play? _____

We are always trying to keep waiting times as short as possible. We therefore ask you to contact us at least 24 hours in advance of you need to cancel your appointment. Appointments, which are not cancelled, can only be rescheduled during mornings.

We offer exclusively digital x-ray technology in order to reduce the exposure to our patients. This service is recommended by the dental association and carries additional cost vs. conventional x-rays technology.

I declare these statements to be true to the best of my knowledge. I give my consent to the preparation of diagnostic documents as required for the treatment. Invoicing is prepared in accordance with the relevant medical legislation and dental tariff regulations (GOZ). It is important to understand that payment of invoices is in no case dependent on the reimbursement for such treatment from your medical insurance or other reimbursing entity. The different contractual arrangements are the basis for this, i.e. we have a legal agreement with you, whereas you have an agreement with the reimbursing entity. Invoices are to be paid in full within the standard payment period. I declare that I give my consent to archive required data in the practice and if necessary to transfer the data to a billing center for further processing.

Place and date:

_____

Date & Signature of Guardian/Parent, Patient

Information about Data Protection:

Dear patients,
In accordance with the new data protection laws, we are obliged to inform you on the subject of "data protection". We would therefore like to inform you about the following procedure in our practice and then request your consent by signing our internal data protection measures listed below:

Information about the internal handling of the current 'fundamental data protection regulation'
- In our practice, patient data is collected, processed and stored electronically right from the start.
- Within our practice, all medical and non-medical staff have access to your patient data. All employees are committed to data protection and have signed a confidentiality agreement at the beginning of their employment in our practice.

Einwilligungserklärung:

Data protection measures to protect your patient data	**I consent:**	**I do not consent:**
- If a consultation or treatment takes place in our practice, we may request your patient data from co-treating colleagues or transfer your patient data to co-treating or further-treating colleagues because they are required by us or our colleagues (e.g. within the framework of a council or an expert procedure). Co-treating colleagues can be dentists, physiotherapists, speech therapists, oral surgeons and clinics. The transmitted patient data can be, for example, doctor's letters, reports of findings or x-rays or similar. We will contact you by phone, by mail or by letter.	❑	❑
The patient data collected, processed and stored in our practice may be transferred by us to the following service providers with whom we cooperate: - KZV Nordrhein, Lindemannstraße 34, 40237 Düsseldorf - Align Technology Inc., Arlandaweg 161, 1043 HS Amsterdam, Niederlande - CaDigital GmbH, Walder Straße 53, 40724 Hilden - Ormco Europe BV, Basicweg 20, 3821 BR Amersfoort, Niederlande - Kieferorthopädisches Fachlabor E. Van Hemert GmbH, Mittelstraße 106, 53474 Bad Neuenahr-Ahrweiler - Dreve ProDiMed GmbH, Max-Planck-Straße 31, 59423 Unna - Flemming Dental Bonn, Auf dem Kirchbüchel 7, 53127 Bonn - Didacom GbR, Konrad-Adenauer-Straße 25, 53343 Wachtberg - Your governmental insurance (Krankenkasse), your private insurance	❑	❑

By signing this form I agree to the data protection measures of Praxis Kieferorthopädie Bad Godesberg. I am aware that I can revoke this declaration in whole or in part at any time for the future. I have read and understood this message.

Patient's surname, name: _____

Patient's birthdate: _____

Surname, Name of the insured individual: _____

Surname, Name of the legal guardian: _____

Email Address: _____

_____
Parent's/legal guardian's signature