Dental Team Lucerne
Clinic Dr. Schulte
Winkelriedstrasse 37
6003 Luzern – Tel. 041 210 58 58
www.ztlu.ch

ZahnarztTeamLuzern

Registration for paediatric dentistry

We kindly ask you to fill out this health questionnaire. Your information will be kept confidential.

Child: Last name: First name: Date of birth:

Legal guardian: Last name: First name:

Street: ZIP/City:

Home phone (parents): Work phone (parents):

Cell phone: E-Mail: @ .

May we send your correspondence (recall letters / bills / cost estimates) via E-mail? ☐ yes ☐ no

Shall we send you a reminder the day before your appointment ☐ yes, per email ☐ yes, per SMS ☐ no

Were you referred to us? By whom?:

Do you receive support from social services? ☐ yes ☐ no

Does your child have an acute toothache presently? ☐ yes ☐ no

Has your child already been in treatment by a dentist? ☐ yes ☐ no

Has your child ever had a negative dental experience? ☐ yes ☐ no

Has your child had an accident involving the teeth? ☐ yes ☐ no

Nutrition

Does your child eat / drink a lot of sweets /sweetened drinks? ☐ yes ☐ no

Did your child drink from a bottle? ☐ yes ☐ no

If yes, what kind? _____ For how long / still?_____

Does your child suck his thumb or a pacifier? ☐ yes ☐ no

If yes, what? _____ For how long / still?

Weight of your child in kg _____

Medical Questions

Children's doctor, name and location _____

Does your child suffer from congenital disorders? ☐ yes ☐ no

If yes, which? _____

Has your child recently been in treatment by a doctor ☐ yes ☐ no

If yes, for which illness? _____

Does your child take any medication? ☐ yes ☐ no

If yes, what and how much? _____

Please fill out also the second page of this questionnaire

Does your child suffer from any of the following conditions?

Heart defects or other heart disorders? ☐ yes ☐ no

If yes, which? _____

Allergies:

Does your child have an allergy to any medications or materials? ☐ yes ☐ no

If yes, which? _____

Does your child have an allergy passport? ☐ yes ☐ no

Does your child suffer from asthma or hay fever? ☐ yes ☐ no

Blood and infectious diseases

Blood disorders, haemophilia ☐ yes ☐ no

If yes, which? _____

Has your child had bleeding problems after dental treatment? ☐ yes ☐ no

HIV / AIDS ☐ yes ☐ no

Hepatitis A ☐ / B ☐ / C ☐ ☐ yes ☐ no

If yes, when was the diagnosis ? _____

Other conditions

Diabetes ☐ yes ☐ no

Epilepsy, seizures ☐ yes ☐ no

Cancer, leukemia ☐ yes ☐ no

If yes, which / when? _____

Other illnesses not listed here ☐ yes ☐ no

If yes, which? _____

Caution: After dental treatment using sedation or after treatment under general anesthesia, do not leave your child to play or walk about unattended!

Date: _____

Signature of the legal guardian: _____