Kinderzahnarztpraxis Dr. Bettina Brem

L a c h e n d e K i n d e r – l a c h e n d e Z ä h n e

Patient's Application Form

Name of the child (first & last name)	
Date of birth	
Address	

Name of the mother (first & last name)	
Date of birth	
Telephone private	
Telephone business	
Mobile phone	

Name of the father (first & last name)	
Date of birth	
Telephone private	
Telephone business	
Mobile phone	

Legal guardian: ☐ Mother ☐ Father ☐ Other

How is your child insured?
☐ Private health insurance
☐ Statutory health insurance
☐ Voluntary statutory health insurance

Name of the health insurance company / insurance carrier:

I would like to be reminded of the next check-up by text message: ☐ yes ☐ no

How did you find out about our surgery?

Date **Signature**