

**Dear Parents,
Welcome to our Practice!**

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Before we turn our attention to your child, we would like to ask you to answer the following questions. This information helps us with the comprehensive care of your child. The answers are voluntary and are of course subject to medical confidentiality.

Child's Name: _____ Date of Birth: _____

Address: _____

Telephone Number (private): _____

Mother's Name: _____ Date of Birth: _____

Occupation: _____

Mobile phone: _____

Father's Name: _____ Date of Birth: _____

Occupation: _____

Mobile phone: _____

Who cares for the child? Both parents Mother Father Other

Health insurance: Insured through: Mother Father Other

Address of the main insured person, if different from that of the child:

State Health Insurance: _____

Private Health Insurance: _____

Are there any special family situations (i.e. single parent, serious disease of a family member, recent move, separation, death)?

Siblings (name, age, any health issues):

Languages spoken at Home:

Hospitalizations:

Surgeries:

Does your child take any medications (including ointments) no

yes

>> If yes, please list (including dosage):

Previous Paediatrician?

How did you hear about our practice?

Recommendation:

Internet (or similar):

Other:

Have we forgotten anything/ is there anything else you would like to tell us?

This form was filled out by Mother / Father / Other

Date _____ Signature: _____

Thank you so much for your help!