CenDenta
ZENTRUM FÜR ZAHNMEDIZIN
MEDIZINISCHES VERSORGUNGSZENTRUM

Patient data form

Dear patient, we are pleased about the trust you have placed in us and we would like to treat you with the best possible precaution and dental care. In order to be able to guarantee this, we ask you to provide us with your personal data and information about your general state of health. Your details are subject to medical confidentiality and data protection! If there are any uncertainties when filling in the form, please ask our staff.

☐ Male ☐ Female | Title

Name | Surname | Date of birth

Insured member Family name | Surname | Date of birth

Street / number | Telephone private

ZIP-Code / City | Mobile

Name of health insurance company | E-mail

Profession

Employer (voluntary) | Telephone workplace (voluntary)

Il would like to be reminded of the six-monthly check-up. ☐ yes ☐ no

I assure that I have duly filled in the above personal data.

The services to be invoiced privately will be invoiced at the end of the treatment or at the end of the month.

For statistical purposes we would like to know how you became aware of us.

☐ Family/acquaintances ☐ Internet ☐ press, which ones? _____

☐ Referral, by whom? _____

You are coming for treatment to a practice that is run according to the ordering system. This means that if you are unable to keep agreed appointments, you must cancel them at least 24 hours in advance so that we can schedule the time allocated for you elsewhere. This agreement not only serves to avoid waiting times in the organizational sense, but also establishes mutual contractual obligations. Thus, if you do not cancel the appointment in time, you can be charged the planned time and the remuneration or the unused time in the amount of 100€ according to § 615 BGB, unless you are not at fault for missing the appointment. It is agreed that otherwise default of acceptance occurs if the agreed date is not cancelled and kept in time.

Date | Signature

As a patient, I hereby declare my consent to the transmission of correspondence by e-mail via the Internet or by SMS by CenDenta to myself or to us and third parties. For reasons of simplification and acceleration, permission is granted with knowledge of the risks of the communication channel, notwithstanding the fact that interference may occur and confidentiality obligations may be compromised.

I hereby confirm, insofar as I have provided a fax number, that only I or persons appointed by me have access to this fax machine or fax connection and that I check my fax receipts regularly.

Until revoked, I agree that CenDenta may send me information without restriction via my e-mail address, fax or SMS.

The patient is hereby informed that the customer's data entrusted to CenDenta will be collected, stored and processed with data processing equipment in accordance with the law and within the scope of the contract. With my signature I declare my consent and I have also received the patient information on data protection.

Date | Signature

CenDenta
ZENTRUM FÜR ZAHNMEDIZIN
MEDIZINISCHES VERSORGUNGSZENTRUM

Allergies ☐ yes ☐ no Do you have an allergy pass? ☐ yes ☐ no

Drug allergy (e.g.: penicillin, iodine)?

Are there any allergies/compatibilities to materials (e.g.: latex, metals)?

Circulatory diseases

Blood pressure ☐ low ☐ regular ☐ high

Heart diseases

If so, which heart diseases?

Do you have a heart pass? (Herzpass) ☐ yes ☐ no

Heart rhythm disturbances ☐ yes ☐ no

Heart valve ☐ yes ☐ no

Stroke When? ☐ yes ☐ no

Heart attack When? ☐ yes ☐ no

Metabolic diseases

Diabetes ☐ yes ☐ no

Thyroid dysfunction ☐ yes ☐ no

Blood diseases

Thrombosis ☐ yes ☐ no

Leukemia ☐ yes ☐ no

Blood clotting disorders ☐ yes ☐ no

Infectious Diseases

Tuberculosis ☐ yes ☐ no

HIV/AIDS ☐ yes ☐ no

Hepatits (If yes, which ones:)

Suffer from:

Asthma ☐ yes ☐ no

Epilepsy ☐ yes ☐ no

Osteoporosis ☐ yes ☐ no

Pain/noise in the temporomandibular joint (e.g. chewing) ☐ yes ☐ no

Bleeding gums / receding gums ☐ yes ☐ no

Pain in the head, neck and throat area ☐ yes ☐ no

Are you suffering/suffering from a malignant disease? (Cancer) ☐ yes ☐ no

Do you get or did you get a Radiation, chemotherapy ☐ yes ☐ no

Do you have glaucoma? ☐ yes ☐ no

Do you have gastrointestinal problems? e.g. ulcerative colitis/Morbus Crohn's disease ☐ yes ☐ no

Do you regularly take medication (e.g.: blood pressure medication; heart medication, ASS, Marcumar or similar)? If so, which ones?

Do you receive or have you been given medication (tablets/infusions/injections) to build up bone, e.g. osteoporosis, bone metastases or Paget's disease? If so, since when? Which preparations (e.g. alendronate, Bonviva, XGEVA, zoledronate)?

Do you have any other diseases or disabilities not mentioned here? If so, which ones?

You smoke? If so, how much/day?

When were you last x-rayed in the jaw area?

Are you pregnant? ☐ yes ☐ (week) ☐ no ☐ Uncertain

Are you satisfied with the position/colour/ form of your teeth, in short with your smile? ☐ yes ☐ no

Is there interest in bleaching/whitening? ☐ yes ☐ no

Many thanks for your cooperation. Please let us know if there have been any changes.

Date

Signature

In order to shorten your waiting time with us, please bring the completed medical history form to your first appointment.