Ganzheitliche Zahnarztpraxis

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Welcome to our practice!

Before we can discuss your dental wishes in peace, we need not only your personal details but also information about your general health. This is important for risk-free treatment. All information is subject to medical confidentiality.

Patient (Mr/Mrs/Child)

Surname _____ First name _____ Date and place of birth _____

Main insured person
If the patient is not the main insured person

Surname _____ First name _____ Date and place of birth _____

Address

Street / number _____ Postcode _____ Location _____

Mobile phone number _____ Tel. during the day _____ E-mail _____

Name of the health insurance company or insurance company _____

Are you entitled to assistance? ☐ **Yes** ☐ **No**

Employer _____

Practiced profession/function _____

For patients with statutory health insurance (health insurance patients)

Please remember to bring your health insurance card with you on your first visit of the quarter. If we do not have your current insurance card, even 14 days after the treatment, we must consider you as a private patient and issue you a private invoice according to GOZ (Fee Regulations for Dentists).

For all patients

Local anesthesia may impair your ability to drive a vehicle. We therefore ask you to take this into account when planning your appointments and travel.

Place, date _____ Signature _____

How did you hear about us?

☐ Via recommendation from one of our patients _____ ☐ Via Internet ☐ Miscellaneous _____
Surname, first name

Do you consider yourself a "fear patient"? ☐ **Yes** ☐ **No**

If so, what do you expect from us so that we can properly deal with you as an anxious patient?

_____

Billing center:

Since we would rather concentrate on perfect dental treatment than on invoicing and checking incoming payments, we have transferred the billing area to a dental billing office, DZR. This has many advantages for you as a patient, as you will be supported free of charge if you have any disputed questions with your insurance company. You also have many flexible financing options, with up to 6 installments free of interest and fees, or up to 48 installments starting at 50 euros per month. Do not hesitate to contact our receptionist if you have any questions about financing or partial payment.

Appointments canceled at short notice or not kept:

We always try to save you long waiting times. We therefore ask you to cancel agreed appointments at least 48 hours in advance if you are unable to attend. This means we can offer these free appointments again to patients on a waiting list. We therefore ask you to understand that if appointments are not canceled 48 hours in advance or are not kept, we also have to charge members of the statutory health insurance a cancellation fee of up to 180 euros per hour of cancellation.

Would you like us to remind you of your check-ups/prophylactic appointments in the future? Don't hesitate to ask your dentist or our assistants about this.

☐ Yes ☐ No

_____ _____

Place, date Signature

Recording sheet

Surname _____ First name _____ Date of birth _____

Have you had any dental treatment recently? ☐ Yes ☐ No

Do you suffer from: ☐ Gum problems ☐ Hypersensitive teeth ☐ Herded teeth ☐ Periodontitis
☐ TMJ problems ☐ Migraine ☐ Tinnitus ☐ Bad breath

Medical treatment
Are you currently receiving medical treatment? ☐ Yes ☐ No
If yes, due to which illness? _____
Do you need endocarditis prophylaxis? ☐ Yes ☐ No
Are you taking bisphosphonates? ☐ Yes ☐ No

General practitioner/specialist
Surname _____ Telephone number _____

Medication
What medications do you take regularly? Against/for what? _____

Allergies
To which substances or medications do you suspect you have a hypersensitivity or allergy?

Heart disease
Do you suffer from any heart disease? ☐ Yes ☐ No
If yes, which? _____
Heart attack? If so, when? _____ ☐ Yes ☐ No
Have you had heart surgery? Cardiac catheter? Pacemaker? Defibrillator? ☐ Yes ☐ No

Circulatory diseases
Blood pressure too high? ☐ Yes ☐ No
Blood pressure too low? ☐ Yes ☐ No
Are you taking anticoagulant medication?
(Marcumar/ASA patient?) ☐ Yes ☐ No
Fainting spells? ☐ Yes ☐ No

Internal diseases
Diabetes? ☐ Yes ☐ No
Thyroid disease? ☐ Yes ☐ No
Renal dysfunction ☐ Yes ☐ No

Blood disorders
Bleeding tendency (= hemophilia)? ☐ Yes ☐ No
Anemia? ☐ Yes ☐ No

Infectious diseases
Hepatitis A, B, C ☐ Yes ☐ No
HIV/AIDS ☐ Yes ☐ No
Miscellaneous _____

More information
Are you addicted to drugs or alcohol? ☐ Yes ☐ No
Do you take stimulants or sedatives? ☐ Yes ☐ No
If yes, which? _____

Roentgen
Have you had an X-ray of your head and jaw area in the last year?
Our modern devices ensure the lowest possible radiation dose. ☐ Yes ☐ No

Pregnancy
If yes, which week? _____ ☐ Yes ☐ No

Generally
Nor any illness, disorder or allergy not already mentioned above
is entered? (e.g. asthma, glaucoma (glaucoma), Crohn's disease,
Epilepsy, coagulation disorder, gastrointestinal disease,...). If yes, which? ☐ Yes ☐ No

further→

Would you like advice about: ☐ Dental aesthetics ☐ Amalgam restoration ☐ Implants

How would you rate your smile on a scale of 1 to 10? (1=Poor, 10=Very good)

Circle	1	2	3	4	5	6	7	8	9	10

Thank you for your help! Please notify us immediately of any changes to the above information. Your details will be provided by may be stored electronically by us, but are subject to the strict provisions of medical confidentiality.

I confirm the accuracy and completeness of the above information.

Place, date _____ Signature _____

Data protection declaration of consent

for the processing of personal patient data in accordance with Article 6, 7 Paragraph 1 Letter a GDPR

Our recall system/appointment reminder system

Dear patient,

Are you interested in our reminder service for your annual dental visit? Then may I ask you,
document this with your signature. If you have any further questions, please contact us. We will be happy to answer you.

Patient

Surname _____ First name _____

I am ready to participate in your Recall service and appointment reminder via SMS. I agree to the practice storing my personal data.

I have been informed that I can give this consent at any time in writing or by email to the practice
can be revoked (Art. 7 Para. 3 GDPR).

I am aware that my revocation of my consent, which is possible at any time, does not affect the lawfulness of the processing carried out on the basis of the consent up to the revocation (Art. 7 Para. 3 Sentence 2 GDPR).

I hereby agree to the storage of my personal data for the purpose of appointment reminders via SMS.

Place, date _____ Signature _____