Medical history form

Patient

Last name, Name : _____

Date of birth : _____ Birthplace : _____

Street : _____

ZIP Code : _____ Place of residence: _____

Mobile Phone Nr. : _____

E-Mail : _____

Bank Institute : _____

Account holder : _____

Account number (IBAN) : _____

Bank number (BIC): _____

Insured

Last Name, Name : _____

Date of birth : _____ Birthplace : _____

Street : _____

ZIP Code : _____ Place of residence: _____

Mobile Phone Nr. : _____

E-Mail : _____

Bank Institute : _____

Account holder : _____

Account number (IBAN) : _____

Bank number (BIC) : _____

Information about your health insurance

O statutory: _____

O voluntary insurance O compulsorily

O Private: _____

Registration fort the free appointment service

Good oral hygiene and regular prophylaxis are the best guarantees for healthy teeth. Therefore we higly recommend that you regularly use our control examination and tooth cleaning service.

We would be happy to reach you and offer you regular appointments, you don´t have to remember by yourself when the next control examination and tooth cleaning service is back.

_____ _____

Date Signature of Patient/ Insured

Information regading the patient's medical condition

Have you had any of the following diseases?

O Severe shortness of breath
O Hepatitis O A O B O C
O Diabetes
O Rheumatism
O Seizure disorders (Epilepsy)
O Blood diseases
O Thyroid disorders
O Blood clotting disorders
O HIV- Infection
O Heart attack, if so, when _____
O Tuberculosis
O Stroke, if so,when _____
O Liver diseases
O Paralysis, if so, please specify _____
O Do you wear a pacemaker? if so, how long _____
O Problems to fall asleep or staying asleep
O Alergic reactions
Which? _____
O Other diseases? _____
O Diseases, problems with:

O Stomach & intestines	O Blood pressure
O Heart & cycle	O Stress
O Lungs & Bronchi	O Joints
O Skin & Mucous membranes	O Headaches
O Liver & pancreas	O Psyche

Consumption of

Cigarettes O No O Yes How much: _____
Coffee, tea O No O Yes How much: _____
Narcotics O No O Yes How much: _____
Sleeping pills O No O Yes How much: _____

Do you regularly take any medication?

O Yes, _____ O No

Are you pregnant?

O Yes,_____ Month O No

Here we would like to ask you tot o answer some general questiones.

Which wishes and expectations do you have regarding our treatment?

_____

_____

How would you assess your current dental situation?

_____

_____

How would you assess your current general state of health?

_____

_____

How many children unser 18 years live in your household? And how old are they?

_____

_____

Is there any specific reason why you have chosen our practice?

_____

_____

General questionnaire to determine functional disorders oft the temporomandibular system (TMD, Tempomandibular dysfunction)

	Yes	No
Do you feel that your bite is not correct?	O	O
Is your lower jaw limited in mobility?	O	O
Do you suffer from pain in your ear and jaw joint region?	O	O
Do you notice any cracking or grating noises while opening or closing your mouth or chewing?	O	O
Do you have tension in your neck and/ or shoulder muscles?	O	O
Do you grate or gnash your teeth?	O	O
Do you suffer fromheadaches or migraines?	O	O
Do you suffer from tinnitus or ringing in the ears?	O	O
Do you have balance problems or dizziness?	O	O
Do you have temperature-sensitive teeth and/ or exposed necks of the teeth?	O	O

Confirmation of health informations

I hereby confirm that the above information about my state of health is correct or that I have given it to the best of my knowledge and belief.

_____ _____

Date Signature of Patient/ Insured

Communication by E-Mail

Less paper already the environment. Therefore, we are happy to communicate with you by e-mail. We ask for your express consent for this, as we cannot guarantee that e-mail communications cannot be viewed by unauthorized third parties, even in compliance with the highest security standards.

I hereby expressly agree to the communication between me and the dental practice in Johanniscontor – Dr. Hamide Farshi . This consent also includes correspondence containing personal health data. I am aware that this correspondence cannot be guaranteed by unauthorized third parties.

_____ _____

Date Signature of Patient/ Insured

Declarations of consent in accordance with the General Data Protection Regulation (GDPR) for personal data

The protection of your personal data is important to us. According to the EU General Data Protection Regulation (GDPR), we are obliged to inform you about the purpose for which our practice collects, stores, processes or forwards data.

I agree that Dentalpraxis im Johanniscontor - Dr. Hamide Farshi - Große Johannisstr. 19 in 20457 Hamburg, collect, store and process my personal data. The data processing takes place on the basis of legal requirements in order to fulfill the treatment contract between you and your dentist and the associated obligations. For this we process your personal data, in particular your health data. This includes anamnesis, diagnoses, therapy proposals and findings that we or other doctors collect. For these purposes, other dentists, doctors or psychotherapists, physiotherapists, speech therapists, etc., with whom you are receiving treatment, can provide us with data (e.g. in ordinations, referrals, doctor's letters, etc.). The collection of health data is a prerequisite for your treatment. If the necessary information is not provided, careful handling cannot take place.

We only transfer your personal data to third parties if this is necessary and permitted by law or if you have given your consent. Recipients of your personal data can primarily be other dentists, doctors or psychotherapists, physiotherapists, speech therapists, dental technicians, the Association of Statutory Health Insurance Dentists, aid agencies, private health insurances, statutory health insurances, experts, the medical service of the health insurance, the dental association and private (dental) medical clearing houses as well Be a tax advisor and the financial administration. The transmission takes place mainly to coordinate dental and interdisciplinary issues relating to your general or your dental health, to bill for the services provided to you, to clarify questions that arise from your insurance relationship.
I am aware that I can revoke this consent at any time without giving reasons for the future by contacting the Dentalpraxis im Johanniscontor - Dr. Hamide Farshi - Große Johannisstr. 19 in 20457 Hamburg by post or by e-mail mail@hamidefarshi.de to inform me of my revocation of the processing of my personal data. The Dentalpraxis im Johanniscontor - Dr. Hamide Farshi - points out that you have the right to information, correction, deletion, restriction of processing, data portability (Art. 15-21 DS-GVO), as well as to complain to a supervisory authority (Art. 77 DS-GVO) .

_____ _____

Date Signature of Patient/ Insured

Appointments and cancellations

If you are not able to make an agreed upon appointment, we kindly request that you inform us promptly (at least 24 hours in advance). This would then give us an opportunity to reschedule and potentially avoid downtime.

For fixed appointments which you fail to make without notifying us, we will charge a cancellation fee in the amount of 75,00 EUR. This rule also applies to the agreed dates for profesional dental cleaning. (However, this does not apply for no-shows which are clearly not the fault of the patient.)

_____ _____

Date Signature of Patient/ Insured