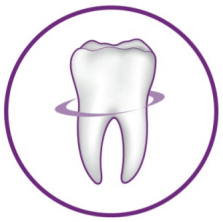
ANAMNESIS



_____/_____
last name & first name | date of birth

_____/_____
last & first name (person stage of beeing under age) | date of birth

_____/_____
adress: street & number | post code & city

_____/_____
telephone- / mobilnumber | email

_____/_____
compulsory health insurance | private insurance

_____/_____
profession | employer

MEDICAL ANAMNESIS

	YES	NO	
1. heart disease, circulatory trouble	◯	◯	_____
2. infectious diseases (hepatitis, AIDS, HIV, tuberculosis…)	◯	◯	_____
3. internal diseases (diabetes, bleeding disorder)	◯	◯	_____
4. allergies to (which substances)	◯	◯	_____
5. Do you take any medicine regularly? (Which?)	◯	◯	_____
6. Other diseases?	◯	◯	_____
7. Are you pregnant?	◯	◯	_____
8. Are you afraid?	◯	◯	_____
9. Do you smoke? How many per day?	◯	◯	_____
10. Do you have a privat dental insurance?	◯	◯	_____

11. Do you agree to take part in our recallprogram (for free)? (only possible with your mobilenumber and email adress)

◯ **Email / SMS** ◯ **No**

12. How did you hear about us? _____

I will inform you about each changing of my indications. I know about the maybe appearing consequences of the anesthesia. Please note we don´t accept travel- or emergency insurances - except emergency treatments. The final accounting is reliant on the dentists´ fee schedule. We ask you to meet agreed deadlines or to cancel 24 hours in advance, otherwise it may be charged for any resulting costs **(cancellation fee - 100€)**.

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date | signature patient

Thank you. Please note that this information are liable to mediacal discretion. They serve exclusively to adapt our treatment to your state of health. Partly they are regulated by law. If it is necessary your data are stored by us. But they subject to strict conditions of privacy - DSGVO (Datenschutzgesetz) since 05/25/18.

please turn over!

Data Protection

Ich stimme hiermit der Speicherung meiner personenbezogenen Daten durch die Praxis zu. Ich bin darauf hingewiesen worden, dass ich diese Zustimmung jederzeit schriftlich oder durch Email an die Praxis widerrufen kann (Art. 7 Abs. 3 DSGVO). Mir ist bekannt, dass mein jederzeit möglicher Widerruf der Einwilligung die Rechtsmäßigkeit der aufgrund der Einwilligung bis zum Widerruf erfolgten Verarbeitung nicht berührt (Art. 7 Abs. 3 Satz 2 DSGVO). Mir ist bewusst, dass meine Daten streng vertraulich behandelt und gegebenenfalls elektronisch gespeichert werden. Sie unterliegen der ärztlichen Schweigepflicht gem. §203 StGB sowie den strengen Bestimmungen des Datenschutzes. Ich habe alle Angaben nach bestem Wissen gemacht.

city:

date:

signature patient: