Gut für die Zähne...

Anamnesis Questionnaire Adults

ZAHNÄRZTE KAISERSTRASSE
Dr. Marquardt | Dr. Roosen

Please take care in filling out this questionnaire. All data are solely for the purpose to adapt our treatment to your state of health. The data are of course bound to our medical confidentiality acc. to § 203 StGB as well as the strict regulations of data protection. If you need help in filling out this form please do not hesitate to ask us.

We herewith point out to you that filling out this questionnaire is by choice. You have always the possibility to assert your right of access.

We also herewith point out to you that during your medical treatment through the doctor or any other staff from Zahnärzte Kaiserstrasse MVZ GmbH more data might be required and processed from you which is necessary for the success of your medical treatment, the administration of the medical treatment documents or the doctor´s bill.

Patient

Surname: _____ health insurance company: _____

First name: _____ Email: _____

Street, no.: _____ Mobile: _____

Postcode/city: _____ Tel. private: _____

date of birth: _____ Tel. business: _____

city of birth: _____

Insured person (if deviant)

Surname: _____ health insurance company: _____

First name: _____ date of birth: _____

Street, no.: _____ Tel. private: _____

Postcode/city: _____ Tel. business: _____

type of insurance

☐ compulsory sickness insured ☐ additional insurance for dental medical treatment ☐ Beihilfe

☐ fully private health insured ☐ basistariff of a private health insurance ☐ voluntarily compulsory sickness insured

Are you entitled to government aid? ..... ☐ yes ☐ no

care level ..... ☐ yes ☐ no

Recall-System

Would you like to be included in our recall system for regular dental check-ups? ☐ yes ☐ no

I am interested in...

☐ implants ☐ premium dental prosthesis ☐ ablation of amalgam filling ☐ prophylaxis

☐ laser surgery ☐ aesthetic dentistry ☐ snore splint ☐ bad breath consultation

☐ bleaching ☐ parodontitis treatment ☐ temporomandibular joint treatment ☐ laughing gas sedation

☐ other: _____

How did we get your intention?

print: ☐ advertisement, which? _____

internet: ☐ doctor´s or health portal, which? _____

☐ google ☐ Gelbe Seiten ☐ homepage of praxis ☐ facebook

other: ☐ window promotion ☐ bus promotion ☐ radio promotion

recommended by: _____

name

Reason of your visit

toothache	☐ yes	☐ no	bad breath	☐ yes	☐ no
gum bleeding	☐ yes	☐ no	teeth grinding	☐ yes	☐ no
snore	☐ yes	☐ no	headache/neck pain	☐ yes	☐ no

Questions to x-ray examination

Have you been x-rayed at your head/neck during the last 12 months? ☐ yes ☐ no

Woman: Are your pregnant? ☐ yes ☐ no If yes, which week?_____

Do you or did you ever suffer from one of the following illnesses? All applicable please tick off.

cardiovascular ☐ cardiac infarction ☐ high blood pressure ☐ low blood pressure
☐ cardiac pacemaker ☐ cardiac valve animal/mechanical

artery ☐ stroke
☐ disfunction of clotting Which kind of?_____

metabolism/diabetes ☐ thyroid illness ☐ diabetes mellitus

contagious disease ☐ hepatitis A/B/C ☐ AIDS/HIV

respiratory system/lung ☐ asthma

nerves/mind ☐ seizure/epilepsy

allergy/hypersensitivity ☐ yes ☐ no If yes, which kind of?_____

bones ☐ osteoporosis

Do you suffer from other illnesses? _____

Medication

Did you ever take Bisphosonates? (e.g. Actonel, Zometa®, Fosamax®, Bonviva) ☐ yes ☐ no

Do you regularly take any medicine? If yes, which kind of? _____

Anticoagulant medicine permanent during the last 10 days

☐ Aspirin (ASS), last 10 days ☐ Marcumar, Xarelto, Eliquis, Plavix

Do you smoke? ☐ yes ☐ no

Do you suffer from gag reflex? ☐ yes ☐ no

Afraid of dentist? ☐ yes ☐ no

Elucidation about risks of dental local anaesthetics in the lower and upper jaw

We are legally obliged to inform you that during the penetration of the acus nervi mandibularis, lingualis and infraorbitalis can be damaged reversible or irreversible. A detailed explanation will be handed over to you together with this anamnesis questionnaire.

With your signature you confirm the completeness and correctness of your data as well as your agreement to the terms and conditions of the medical treatment.

In your own interest we ask you to tell us any variance in your health and medication.
The health risks need to be checked and confirmed with your signature every 12 months.

I herewith confirm with my signature that

- I understood the explanations from the questionnaire. The conclusion of my medical contract is not dependent on my data. I confirm that this agreement is voluntary.
- I have been pointed out in advance that I always have the right to cancel the agreement in total (or partially) for the future by written notice (email is sufficient).
- the data privacy statement of Zahnärzte Kaiserstrasse MVZ GmbH has been provided to me. I have registered this statement and decided that I do not want to take an own sheet home. I have been explained that I can look at the data privacy statement always in the practice or on the website.
- I have received and took notice of the elucidation about risks of dental local anaesthetics.

Mülheim an der Ruhr, date _____ signature _____ Mülheim an der Ruhr, date _____ signature _____

Mülheim an der Ruhr, date _____ signature _____ Mülheim an der Ruhr, date _____ signature _____

Consent form*

Patient

Surname/First name: _____

Date of birth: _____

Street/house no.: _____

Postal code/City: _____

ZAHNÄRZTE KAISERSTRASSE
Dr. Marquardt | Dr. Roosen

ZAHNÄRZTE KAISERSTRASSE MVZ GmbH
Kaiserstrasse 20 | 45468 Mülheim an der Ruhr
Fon 0208.976 99-0 | Fax 0208.976 99-10
www.zahnaerzte-kaiserstrasse.de

Doctor (practice stamp/clinic stamp)

Legal representative (s) in the case of minors / legally incompetent people / people with limited competence

Surname/First name: _____ Date of birth: _____

Street/house no.: _____ Postal code/City: _____

Dear patient,
We want to focus fully on you and your treatment. This why we have decided to transfer the billing to a competent partner:

BFS health finance

BFS health finance GmbH
Hülshof 24, 44369 Dortmund

Tel.: 0231-94 53 62-600
Fax: 0231-94 53 62-688
patientenservice@meinebfs.de

BFS guarantees the speedy, uncomplicated and accurate processing of your bill. As your friendly and competent partner in all aspects of the billing, it offers partial payment options on request.

In order to enable billing in cooperation with BFS, we require your written consent. We therefore request that you give your consent by signing the adjacent declarations.

Thank your for your conficence.

TÜVRheinland ZERTIFIZIERT — Dienstleister mit geprüftem Datenschutzmanagement — www.tuv.com ID 0000044064

I confirm my agreement with

- any request by the doctor to the BFS regarding billing through BFS, even before the start of treatment,

- the obtaining of credit information at a credit bureau by BFS (stating the name, date of birth and address of the patient/payer), as far as necessary,

- assignment of claims arising from treatment to BFS,

- further assignment of claims by BFS to the refinancing bank (Landesbank Hessen-Thüringen clearing house),

- transmission of the information necessary for billing and enforcement of claims (eg name, date of birth, address, diagnosis, treatment codes, treatment details and processes) to BFS and possibly to the refinancing bank,

- temporary use of my data by BFS for testing the development system and optimisating internal billing processes, with subsequent deletion of the data.

I have been informed that BFS will bill me for the services by my practitioner and will claim the invoice amount from me.

If there is a disagreement about the validity of the claim, the medical practitioner may be heard in a possible conflict as a witness.

After the process is complete, the data will be deleted. The statutory retention periods apply.

Release from confidentiality

I release my medical pratitioner, his representatives and BFS from their obligation of confidentiality within the setting described.

The above statements may be revoked in writing with effect for the future.

Mülheim an der Ruhr, date _____ signature of patient or legal representative _____

Mülheim an der Ruhr, date _____ signature of patient or legal representative _____

Mülheim an der Ruhr, date _____ signature of patient or legal representative _____

Mülheim an der Ruhr, date _____ signature of patient or legal representative _____

* Deletions of and/or changes to the foregoing explanations are not permitted and make the consent invalid.