TAGESKLINIK

FÜR MUND-, KIEFER-, GESICHTSCHIRURGIE

PRAXISGEMEINSCHAFT

DR. DR. MED. PETER GORENFLOS
Maxillofacial Surgeon

DR. MED. DENT.CECILIA ZAWADZKI
Oral Surgeon

DR. DR. MED. CHRISTOPHER SCHARDT
Maxillofacial Surgeon

Dear patient.
Welcome to our clinic.
Please fill the following registration and medical form.
Thank you!

PATIENT DATA

☐ male ☐ female

Name

First Name

Date of birth Place of birth

Street, No.

Postcode City

Home telephone

Mobile phone

e-mail

Occupation

INSURANCE

Health insurance

☐ Statutory health insurance ☐ Private health insurance

Additional health insurance? ☐ Yes ☐ No

Are you the main Insurer,
if not, who is?

☐ male ☐ female

Name

First Name

Date of birth Place of birth

Street, No.

Postcode City

TREATING DOCTORS

Name of dentist

Name of general practitioner

GENERAL INFORMATION

How did you hear about us?

☐ Family / friends / acquaintances
☐ Internet (search query)
☐ Newspaper (e.g., advertisement)
☐ Doctor
☐ Miscellaneous:
☐ Dentist
☐ Practice sign
☐ Website

HEALTH QUESTIONS

Do / did you have any of the following diseases?	Yes	No
Allergic reactions, drug intolerance	☐	☐
If yes, which?		
Heart disease	☐	☐
If yes, which?		
Do you have a pacemaker?	☐	☐
Do you have a heart pass?	☐	☐
Heart attack	☐	☐
If yes, when?		
Stroke	☐	☐
If yes, when?		
Liver diseases, jaundice (hepatitis A, B, C, D)	☐	☐
Renal disease	☐	☐
Diabetes (Diabetes mellitus)	☐	☐
Epilepsy	☐	☐
Rheumatism	☐	☐
Cancer diseases	☐	☐
Infectious diseases (HIV, hepatitis)	☐	☐

	Yes	No
Hematological disorders, blood clotting disorders	☐	☐
Do you take blood thinners?		
If yes, which?	☐	☐
Other diseases?	☐	☐
If yes, which?		
Do you take medication on a regular basis?	☐	☐
If yes, which?		
Treatment with bisphosphonates in osteoporosis or bone metastases?	☐	☐
Do you have an X-ray registration card?	☐	☐
When was the last dental X-ray?		
Are you pregnant?	☐	☐
Do you smoke?	☐	☐

Please inform us of any changes to your medical conditions and/or address.

With my signature, I confirm the completeness and accuracy of the given information.

Place, Date

Patient, Guardian

CONSENT OF X-RAY PICTURES / RIGHTS OF USE / COMMUNICATION WITH PRACTITIONER

☐ **X-RAY CONSENT:**
I hereby agree that necessary X-ray examinations can be made during the treatment.

☐ **RIGHTS OF USE:**
I hereby agree that photos and x-rays, which are created during the treatment, may be published anonymously in scientific lectures, publications or further education.

☐ **CONSENT OF COMMUNICATION WITH PHYSICIAN / DENTIST:**
To ensure an ideal match between treating medical colleagues.

☐ **DATA PROTECTION:**

1.) I hereby agree that my personal data are stored in accordance with articles 6 and 7 paragraph 1 of the GDPR at the day clinic. I am aware that this consent can be revoked.

2.) I hereby agree that my doctor and/or dentist as well as the medical staff may process my patient data electronically. This includes, among other things, the forwarding of X-ray images by post and/or e-mail.

3.) I hereby acknowledge and agree that this practice will be video-monitored for security reasons. The storage time of the recording is approximately two weeks.

Place, Date

Patient, Guardian