MEDICAL HISTORY FORM
TO GATHER INFORMATION ABOUT YOU

AVADENT
Zahnmedizin einer neuen Generation.

Dear patient,
welcome to our dental office,

we, the team at AVADENT, would like to make your stay as pleasant as possible. In order to ensure high-level care for you and to address your individual health and personal needs effectively, we require information about your health in addition to your personal details. This is important for ensuring the most effective treatment with minimal risk. If you have any questions, we are here to assist you. Your information is subject to medical confidentiality according to § 203 of the German Criminal Code and will of course be treated confidentially.

PERSONAL INFORMATION

Title ○ Mr. ○ Mrs. ○ Other

Family name _____ First name _____

Date of birth _____ Place of birth _____

Street · House number _____ ZIP code · City _____

Phone (private) _____ Phone (business)* _____

Phone (mobile)* _____ Profession** _____

Email* _____

HEALTH INSURANCE (Please check where applicable)

○ Statutorily insured ○ Voluntarily insured ○ Mandatorily insured ○ Eligible for benefits

○ Privately insured ○ Privately supplemented insurance ○ Privately insured basic tariff

○ I am receiving long-term care benefits Level of care (1–5) _____

INSURED PERSON (If different from patient, please check where applicable)

Title ○ Mr. ○ Mrs. ○ Other

Family name _____ First name _____

Date of birth _____ Place of birth _____

Street · House number _____ ZIP code · City _____

Primary care physician *** _____ City _____

HOW DID YOU FIND US?**** (Please check where applicable)

○ Website ○ Google ○ Advertisement ○ Social media

○ Doctolib ○ Recommendation _____

○ Dentist referral _____

Please answer the health questions listed on the other side of the page so that we can better respond to your wishes and avoid general medical risks for you. Your personal data will of course be treated confidentially.

* Voluntary information · if you wish to be contacted by us about medical matters via this communication medium.
** Voluntary information · may assist in treatment
*** Voluntary information · if it makes sense to request documentation for your treatment, we will contact you for consent.
**** Voluntary information · for this purpose, we collect internal practice statistics.

PLEASE TURN

HEALTH QUESTIONS (Please check where applicable)

Do you suffer from any of the following conditions?

- ○ heart attack
- ○ coronary artery disease
- ○ arrhythmias
- ○ pacemaker
- ○ valve replacement
- ○ heart defects · endocarditis
- ○ high blood pressure
- ○ low blood pressure
- ○ stent
- ○ diabetes mellitus (diabetes)
- ○ blood disorders · coagulation disorders
- ○ joint replacement
- ○ thyroid disease
- ○ osteoporosis
- ○ liver diseases
- ○ kidney diseases
- ○ diseases of the respiratory organs · asthma
- ○ gastrointestinal

INFECTIOUS DISEASES

- ○ hepatitis ○ A ○ B ○ C
- ○ HIV · AIDS
- ○ tuberculosis
- ○ hospital-acquired infections (e.g. MRSA etc.)
- ○ Creutzfeldt-Jakob (CJD) · CJD variants
- ○ others _____

ALLERGIES AND INTOLERANCES

- ○ antibiotics · penicillin
- ○ painkillers
- ○ anesthesia injections
- ○ latex
- ○ plastics
- ○ metals
- ○ others _____

TUMOR DISEASES (also in the past)

- ○ cancer
- ○ radiation therapy
- ○ chemotherapy

DISEASES OF THE NERVOUS SYSTEM

- ○ seizure disorders
- ○ headaches
- ○ migraines
- ○ sleep disorders
- ○ fainting
- ○ nervousness
- ○ stroke

OTHER INFORMATION

- ○ Do you smoke?
- ○ Are you taking any medication? If yes, please specify _____
- ○ Are you receiving medical treatment for other conditions? If yes, please specify _____
- ○ Do you frequently experience headaches and neck pain?
- ○ Are you pregnant? If yes, which week? _____
- ○ Are you satisfied with the color of your teeth?

GENERAL INFORMATION

I confirm that I have provided all information completely and truthfully and undertake to report any changes in my health status throughout the entire treatment period. I agree that my personal data, findings, and X-ray images that I brought with me and collected here, as well as index card entries and other records, may be accessed by all members and employees of AVADENT GmbH. I also consent to their potential use in anonymous form for scientific studies. I acknowledge receipt of the attached information on data protection. I have received a copy of this declaration of consent. I am aware that appointments at AVADENT GmbH are binding and that in the event of short-notice cancellations and no-shows, I will receive an invoice for the canceled appointment at the rate specified in §§ 611, 615 BGB.

Location · Date _____ Signature _____

INFORMATION ON THE PROTECTION OF YOUR PERSONAL DATA *note on voluntary information

I have been informed that I can revoke my consent for providing voluntary information, which serves as the legal basis for processing, at any time by written notice or email to the practice (responsible for my data) (Art. 7 Para. 3 GDPR). I understand that my withdrawal of consent, which can be done at any time, does not affect the lawfulness of the processing carried out based on the consent given before its withdrawal (Art. 7 Para. 3 Sentence 2 GDPR).

Location · Date _____ Signature _____

We sincerely thank you for taking the time to respond.
Your AVADENT team

AVADENT GMBH

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KÖNIGSTEIN
KÖPPERN

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