



Paroimplantologie®

Dres. Kallweit MVZ

Dear Patient,

Before we dedicate ourselves to your dental wishes, besides your personal data we also need information about your general state of health in order to be able to tailor our treatment specifically for you.

Before we devote ourselves to your dental wishes, we need information about your general state of health in addition to your personal details in order to be able to tailor our treatment to them. Therefore, please fill out the following questionnaire conscientiously and honestly. All information is subject to medical confidentiality and will be treated strictly confidentially.

Your answers to the following health questions are used to **assess your state of health, to plan your individual treatment and to avoid medical emergencies**. Although this questionnaire is a standardized, orderly and effective way as well as a proven procedure for recording your medical history, completing the questionnaire **in writing** is voluntary. You can also choose a personal conversation with one of our employees to answer all questions and they will be recorded to your patient file. **We have to point out that treatment is only possible, if all questions are answered, either in writing or the personal conversation**. The written answer or completion of the present medical history form by you is voluntary, but the general answer to the health questions is **not**. The use of a registration form for the standardized, orderly and effective recording of your medical history is a procedure that has been tried and tested for decades. If you do not wish to fill out the registration form, we will of course still treat you, provided that you answer all the health questions of this form in a personal conversation; the answers are then recorded by one of our employees in your patient file. **We would like to point out that treatment in our practice is not possible without first answering the health questions.**

If, between one treatment and another, there are any **changes to your state of health** you are **obliged to inform us without being asked**. The one-time answer of the health questions before your initial treatment in our practice is necessary, but not sufficient for follow-up treatments. **Please inform us of any changes in your state of health before each treatment without being asked**. As a reminder, we ask you to indicate possible changes once a year by issuing the registration form and asking you to fill it out again.

In order to save you waiting times and to ensure a smooth process in our practice, treatment times in our order practice are reserved exclusively for your treatment. **If you are unable to attend, we urgently ask you to inform us in good time, at least 24 hours before the start of the appointment, of your inability to attend, so that the appointment can be allocated elsewhere if possible.**

Patient

Surname	First name	Date of birth
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Address/ ZIP code/ city

Telephone number/ mobile number/ e-mail address

☐ statutory health insurance ☐ private health insurance ☐ additional health insurance

☐ exemption from co-payment (certificate)

Parent/ legal representative

Surname	First name	Date of birth
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Address/ ZIP code/ city

Telephone number/ mobile number/ e-mail address

If necessary, please add authority of your legal representative.

Do you have a **care level**?

☐ yes

☐ no

If you mark yes, how high is it? Please add a certificate.

Do you have a severely disabled person's certificate ? Please add a certificate.	☐ yes	☐ no
Are you currently in reintegration ? Please add a certificate.	☐ yes	☐ no

X-raying

Have you ever been x-rayed in the head/jaw area?	☐ yes	☐ no
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If you mark yes, when was it? _____

Only for women: Are you actually pregnant?	☐ yes	☐ no
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If you mark yes, which month of pregnancy is it? _____

General medical information

Do you take medication regularly ?	☐ yes	☐ no
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If you mark yes, what are they called? _____

Do you take blood-thinning (anticoagulant) medication?	☐ yes	☐ no
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If you mark yes, what are they called? _____

Are you allergic to certain medications or other substances?	☐ yes	☐ no
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If you mark yes, what are they called? Please add an allergy pass. _____

Do you have or had any of the following health disorders?

Heart disease (e.g. heart attack, angina pectoris, heart failure)	☐ yes	☐ no
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If you mark yes, which one? _____

Do you have a pacemaker ?	☐ yes	☐ no
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Do you have an artificial heart valve ?	☐ yes	☐ no
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circulatory diseases (e.g. high or low blood pressure, stroke)	☐ yes	☐ no
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If you mark yes, which one? _____

Metabolic disorders (e.g. diabetes, thyroid diseases)	☐ yes	☐ no
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If you mark yes, which one? _____

Respiratory diseases (e.g. neurodermatitis, hay fever, asthma)	☐ yes	☐ no
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If you mark yes, which one? _____

Brain and nerve disorders (e.g. seizure disorders, migraines, depression)	☐ yes	☐ no
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If you mark yes, which one? _____

Diseases of the musculoskeletal system (e.g. rheumatism, gout)	☐ yes	☐ no
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If you mark yes, which one? _____

Diseases of the internal organs	☐ yes	☐ no
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(e.g. renal insufficiency, jaundice)

If you mark yes, which one? _____

Diseases of the hematopoietic system (e.g. anemia, hemophilia)	☐ yes	☐ no
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If you mark yes, which one? _____

Diseases of the eyes (e.g. cataracts, glaucoma)	☐ yes	☐ no
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If you mark yes, which one? _____

Do you have or had any of the following infectious diseases?

HIV (AIDS)	☐ yes	☐ no
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Hepatitis	☐ yes	☐ no
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SARS-CoV 2	☐ yes	☐ no
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Tuberculosis (Tbc)	☐ yes	☐ no
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Creutzfeld-Jacob (CJ/vCJ)	☐ yes	☐ no
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MRSA	☐ yes	☐ no
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rubella, mumps, measles, scarlet fever	☐ yes	☐ no
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Other infectious diseases _____

Do you regularly consume alcohol or drugs ?	☐ yes	☐ no
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If you mark yes, which one? _____

Do you **smoke**? O yes O no
If you mark yes, how much per day is it? _____

Dental informations

Do you have any **dentures**? (e.g. dental crowns, dental bridges, dentures) O yes O no
If you mark yes, how old is it? _____

Have you had **periodontal treatment**? O yes O no
If you mark yes, when was it? _____

Do you have pain or cracking noises in the **temporomandibular joint**? O yes O no

Do you suffer from **hypersensitivity of your teeth**? O yes O no

Do you have any **special wishes** for your treatment? O yes O no

If you mark yes, what is it? _____

What topics are you interested in:

- ☐ Dental prophylaxis
- ☐ Tooth preservation
- ☐ Cosmetic dental treatments, e.g. gemstones, bleaching
- ☐ Dentures
- ☐ Veneers, Inlays
- ☐ Dental implants
- ☐ Amalgam replacement
- ☐ Filling materials
- ☐ Other topics, e.g. _____

How did you find us?

- ☐ Social media
- ☐ Doctolib
- ☐ Internet search
- ☐ Health insurance
- ☐ Medical referral by _____
- ☐ Recommendation by _____
- ☐ Other kind, _____

Place & date of signature

Signature of patient/ legal representative

We expressly point out that your ability to react in road traffic may be limited after dental treatment or after local anesthesia and/or medication and ask you to confirm this information with your signature.

Place & date of signature

Signature of patient/ legal representative

I agree that information, including personal data relevant to treatment, may be sent to the above-named e-mail address.

I confirm that I have full access to the above-named email address. I will inform you immediately if this changes or if I want to use a different email address.

I am informed that I can revoke this consent at any time in writing or verbally.

Ort, Datum

Unterschrift Patient/Gesetzlicher Vertreter

Privacy policy

Dear Patient,

As part of your treatment, we need to collect data about you, your insurance status and your state of health. Of course, this information is managed by our practice with the greatest possible care. In order to give you an overview of the data held about you and the data protection of the practice, the following information is enclosed:

1. Who is responsible for data protection in our practice?

Responsibility for data protection and is available to answer any questions you may have:

Practice owner	Orisus Zahnmedizin MVZ GmbH
Contact person	Dr. med. dent. Susan Kallweit M.Sc. M.Sc. & Dr. med. dent. Mario B. Kallweit M.Sc. M.Sc.
Practice address	Auerbacher Str. 13, 08107 Kirchberg
Phone	037602 - 647 38
Fax	037602 - 649 01
E-Mail	praxis@zahnaerzte-kallweit.de

2. Who is appointed for data protection officer in our practice?

Appointment for data protection officer:

Name	OPTI Health consulting – Michéle Lindner
Address	Eckernförder Straße 42, 24398 Karby
Phone	04644 – 95 89 00
E-Mail	datenschutz@opti-hc.de

3. Purpose and legal basis of data processing

We collect and process your personal data as a patient of our practice in the context of admission, anamnesis, diagnosis, therapy, as well as master data management, service billing and follow-up care.

For the initiation and duration of a treatment relationship, we have to collect and process different data from you. As part of the treatment contract, we collect in particular your first and last name, date and place of birth, your address, your contact details such as telephone and mobile phone number and your e-mail address, your insured status, your profession, as well as information about your state of health, diagnoses and treatments. Without the collection and storage of your personal data, treatment is not possible.

The legal basis for this type of data processing is in particular Art. 6 para. 1 a), b) EU General Data Protection Regulation (GDPR). Processing on the basis of legitimate interests is only carried out in the case of Art. 6 para. 1 f) GDPR.

4. Data exchange with service providers and other consignees

In order to fulfil our contractual and legal obligations, we use external service providers, such as a dental laboratory, a billing company, a tax consulting company, lawyers and software development companies, to whom we transmit your personal data if necessary.

In addition, we or the aforementioned service providers may transmit your personal data to other consignees, such as authorities for the fulfilment of statutory notification obligations (e.g. statutory health insurance, statutory accident insurance, the medical service of the health insurance companies, or tax authorities). The data will only be passed on to the extent necessary or to the extent agreed by you.

5. Duration of data storage

We will delete your personal data as soon as it is no longer necessary for the purposes set out above. In this context, personal data may be retained for the time in which claims can be made against our practice (in accordance with the statutory limitation periods). In addition, we store your personal data to the extent that we are legally obliged to do so. Corresponding obligations to provide evidence and retain health data (such as the

patient file), the Commercial Code and the Tax Code result from the Patients' Rights Act (BGB §630f para. 3) and the X-ray Ordinance (RöV §28 para. 3), the Commercial Code and the Tax Code. The storage periods are up to 10 years according to the Civil Code, the Commercial Code and the Tax Code, and up to 30 years according to the X-ray Ordinance.

6. Rights of data subjects

You can obtain information about the data stored about you at the above address demand. In addition, under certain conditions, you can request the correction or deletion of your data. You may have a right to restrict the processing of your data as well as a right to have the data you provide in a structured, commonly used and machine-readable format. If you have given separate consent to the processing of personal data, you can revoke your consent at any time. By revoking consent, the data processed until the revocation remains lawfully processed. The withdrawal of consent must be declared to the same body to which you have also given your consent. You have the option of contacting the data protection officer in our practice or the responsible data supervisory authority with a complaint.

7. Data transfer to a third country

If we transfer personal data to service providers outside the European Community, we will only do so if the third country has been confirmed by the EU Commission to have an adequate level of data protection or if other appropriate data protection guarantees (e.g. binding internal company data protection regulations or EU standard contractual clauses) are in place.

Date of signature:	Signature:

Privacy information about Doctolib

For optimal appointment management, we use Doctolib's appointment management system. Doctolib offers us on the one hand a modern calendar system and on the other hand our patients have the opportunity to <https://www.doctolib.de/> to make appointments with us online. Doctolib GmbH (Mehringdamm 51, 10961 Berlin) acts as a processor for us.

We use the Doctolib calendar software for all our patients (regardless of whether the patient is a Doctolib user account for online booking or not) to manage appointments consistently. Doctolib processed all data in accordance with all applicable data protection regulations and applies the highest security standards. When making an appointment, the following data will be entered in the Doctolib calendar: surname, first name, date of birth, address, telephone number, e-mail address, family doctor, health insurance status, referring doctor, reason for visit and appointment history.

Your data will be collected for the purposes of managing appointments, as was previously the case with us. The legal basis for the processing of your data is Art. 6 I b) GDPR (the treatment order that you send to us). Art. 6 I a) GDPR (consent for appointment reminders by SMS and e-mail) and Art. 9 II h) GDPR (the health care purposes). The data are compiled in parallel with the professional law retention obligations for a period of 10 years. The data will not be forwarded by Doctolib to commercial vendors. Doctolib is contractually bound to the duty of confidentiality in accordance with §§ 203, 204 StGB beholden. A release from the duty of confidentiality is not necessary.

In order to reduce appointment cancellations, we would like to inform you with your consent via the Doctolib calendar system via SMS and/or email reminder of your appointment. If you no longer wish to receive reminders, let us know at any time and we will reinstate the reminders.

Special features of online booking

A Doctolib user account is required for online appointment booking, for which the data protection information of Doctolib, which are available on the website [doctolib.de](https://www.doctolib.de). To create a Doctolib user account, the Doctolib GmbH (Mehringdamm 51, 10961 Berlin) is responsible for data processing.

Consent to appointment reminders and recalls via SMS and/or e-mail

In order to reduce appointment cancellations, we would like to send you an SMS and e-mail to remember your appointment. Please confirm with your signature that you agree to this. If you do not want to receive any more reminders, let us know at any time and we will restore the memories from.

☐ Yes, I would like to receive appointment reminders. ☐ No, I don't want appointment reminders.

I would like to attend check-ups as well as agreed or medically necessary treatment appointments and I am willing to participate in a reorder system. Should I no longer wish this, I can revoke my consent to this at any time.

☐ Yes, I would like to receive recalls. ☐ No, I don't want to receive recalls.

Place & date of signature

Signature of patient/ legal representative