



Medical history

Name: _____ Surname: _____

Adress: _____ Post Code/Zip-Code: _____

Phone: _____ E-Mail: _____

Date of Birth: _____ Place of Birth: _____

Occupation: _____ Health Insurance: _____

- | | | |
|---|--|--|
| <input type="checkbox"/> Public Insurance | <input type="checkbox"/> Private Insurance | <input type="checkbox"/> Supplementary Insurance |
| <input type="checkbox"/> European Health Insurance Card | <input type="checkbox"/> Basic Cover | <input type="checkbox"/> On state benefits |

How did you find about us?

- | | | |
|--|--|---|
| <input type="checkbox"/> Personal recommendation | <input type="checkbox"/> In passing | <input type="checkbox"/> Advertisement _____ |
| <input type="checkbox"/> GP referral | <input type="checkbox"/> from the Internet | <input type="checkbox"/> Other (please state) |

Your general health:

Do you suffer from – or have you had – any of the following!

- | | yes | no |
|------------------------|--------------------------|--------------------------|
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Haemophilia | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiovascular disease | <input type="checkbox"/> | <input type="checkbox"/> |

If so, which:

- | | yes | no |
|----------------------|--------------------------|--------------------------|
| Thyroid condition | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatoid arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergic reactions | <input type="checkbox"/> | <input type="checkbox"/> |

If so which:

Other diseases:

Do you smoke?

- | | yes | no |
|---------------------------|--------------------------|--------------------------|
| Infectious diseases: | | |
| HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis A, B or C | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Other (Pls. state): _____ | | |

Are you currently taking any medication?

Heart medication: _____

Cortisone: _____

Painkillers/Analgesics: _____

Antidepressants: _____

Blood thinners (e.g. ASS, Marcumar, Heparin): _____

Other: _____

If you are female: Are you pregnant?

Oral health

What is the reason for your visit?

- | | | | |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Check-up | <input type="checkbox"/> Consultation | <input type="checkbox"/> Treatment for dental pain | <input type="checkbox"/> Dental referral |
| <input type="checkbox"/> Second opinion | <input type="checkbox"/> Other: _____ | | |

Declaration

I declare that the information I have given above is correct to the best of my knowledge.

Date/Signature

Appointment

Dentalpraxis
Dr. Frank Friedrich
Uhlandstraße 175
10719 Berlin

TO ALL PATIENTS

Dear Sir or Madam,

Re: Your agreed appointment with us

You have opted for dental treatment and/or prophylactic treatment with us. In your interest and also in the interest of other patients we would therefore ask you to take note of the following regulation:

You hereby declare your agreement to cancel a fixed appointment for treatment by phone (you can also leave a message on our ansaphone) at least 24 hours before the agreed appointment time, if you are unable to keep your appointment.

Should you fail to cancel, or postpone, your appointment within the required time, we would politely point out that in accordance with paragraphs 280, 611 and 615 of the German Civil Code we are entitled to charge you a cancellation fee of up to 90 Euros.

We thank you for your understanding.

Your dental treatment team
Dr. Frank Friedrich

Berlin on _____

Berlin on _____

For the patient

For the dentist Dr. Frank Friedrich

Declaration of consent for the processing of personal patient data in accordance with data protection law Art. 6, 7 Abs. 1 lit. a. DSGVO

**Dental practice
Dr. med. dent. Frank Friedrich
Uhlandstraße 175
10719 Berlin-Charlottenburg**

Our appointment reminder service (recall)

via post, email, SMS, telephone/ call

Dear patient,

are you interested in our reminder service for your annual dentist visit? Then I would like to ask you to document this with your signature. If you have any further questions, please contact me or my staff. We will be happy to answer you.

I am willing to take part in your recall service. In return, I agree to the practice storing my personal data.

I have been informed that I can revoke this consent at any time in writing or by email (datenschutz@zahnarzt-uhland175.de) to the practice (Art. 7 Abs. 3 DSGVO).

I am aware that my revocation does not affect the legality of the consent up to the time of revocation or the processing carried out up to that point (Art. 7 Abs. 3 Satz 2 DSGVO).

Berlin, _____

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Patient

PATIENT INFORMATION ON DATA PROTECTION

Declaration of consent under data protection law in accordance with Article 6, 7 Abs. 1 lit. a. EU General Data Protection Regulation (DSGVO)

Dear patient,

The protection of your personal data is important to us. According to the EU General Data Protection Regulation (DSGVO), we are obliged to inform you about the purpose for which our practice collects, stores, processes or, if necessary, forwards data. Of course, we are still subject to medical confidentiality. From this information you can also find out what rights you have with regard to data protection.

1. RESPONSIBLE FOR DATA PROCESSING

Zahnarztpraxis Dr. med. dent. Frank Friedrich

Uhlandstraße 175 | 10719 Berlin

Contact person: Herr Christian Voigt

Tel.: 030/28 24 566 | Email: datenschutz@zahnarzt-uhland175.de

2. PURPOSE OF DATA PROCESSING

Data processing is carried out based on legal requirements in order to fulfill the treatment contract between you and your dentist and the associated obligations.

For this purpose, we process your personal data, in particular your health data. This includes anamnesis, diagnoses, treatment suggestions and findings that we or, if necessary, other doctors/dentists or physiotherapists collect (such as doctor's letters or X-rays). The collection of health data is a prerequisite for your treatment. If the necessary information is not provided, careful treatment cannot be carried out.

We may also commission an external dental laboratory to carry out prosthetic dental treatment. However, we will always inform you about this separately.

Our practice offers you a recall or appointment reminder system, which is intended to remind you, without obligation, of a due dental check-up or professional teeth cleaning appointment. We may send you information about this once or twice a year (every 6 or 12 months) by post, email or SMS. Of course, you have the right to tell us your preferred transmission method or not to use this service.

3. RECIPIENTS OF YOUR DATA

We only transfer your personal data to third parties if this is required by law or if you have consented to this.

Recipients of your personal data may include other doctors/dentists, physiotherapists, statutory health insurance associations, health insurance companies, the medical service of the health insurance, dental associations, dental laboratories and private medical clearinghouses.

The transmission is mainly carried out for the purpose of billing the services provided to you and to clarify medical questions and questions arising from your insurance relationship. In individual cases, data may be transmitted to other legally authorized recipients.

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4. STORAGE OF YOUR DATA

We only keep your personal data for as long as necessary to carry out your treatment.

Due to legal requirements, we are obliged to store this data for at least 10 years after treatment has been completed. Other regulations may require longer retention periods, e.g. B. 30 years for X-ray recordings according to Paragraph 28 Abs. 3 of the X-ray Ordinance.

5. YOUR RIGHTS

You have the right to receive information about your personal data. You can also request that incorrect data be corrected.

In addition, under certain conditions, you have the right to delete data, the right to restrict data processing and the right to data portability.

Your data is processed on the basis of legal regulations. We only need your consent in exceptional cases. In these cases, you have the right to withdraw consent for future processing at any time.

You also have the right to complain to the responsible data protection supervisory authority if you believe that the processing of your personal data is not taking place lawfully.

**The address of the supervisory authority responsible for us is:
Berlin Commissioner for Data Protection and Freedom of Information
Friedrichstraße 219, 10969 Berlin**

6. LEGAL BASIS

The legal basis for the processing of your data is Article 9 Abs. 2 lit. h) DSGVO in conjunction with Paragraph 22 Abs. 1 Nr. 1 lit. b) Federal Data Protection Act. If you have any questions, please feel free to contact us in confidence.

Your dental treatment team

Dr. Frank Friedrich

Data protection declaration of consent in accordance with Article 6, 7 Abs. 1 lit. a DSGVO

I hereby agree to the storage and processing of my personal data by the dental practice Dr. Frank Friedrich too.

I have been informed that I can revoke this consent at any time in writing (including by email) to the practice (Art. 7 Abs. 3 DSGVO).

I am aware that my revocation of my consent, which is possible at any time, does not affect the lawfulness of the processing carried out based on the consent before its (Art. 7 Abs. 3 Sentence 2 DSGVO).

Berlin, the _____

Signature of the patient