Kieferorthopädie Zentrum Bern AG

MEDICAL HISTORY QUESTIONNAIRE & CONSENT FORM

Patient no.: _____

PLEASE FILL IN USING BLOCK CAPITALS

Personal data

Last name: _____ First name: _____

Street address: _____ Postal code / city: _____

Legal representative: _____

Home phone: _____ Office phone: _____ Mobile phone: _____

If you do **not** wish to receive appointment reminder via SMS, please tick this box. ☐

Nationality: _____

Date of birth (DD/MM/YYYY) __ __ . __ __ . __ __ __ __ Occupation / title: _____

Email: _____

(By providing your email address, you agree that we may send you confidential data electronically regarding appointments, invoices, medical reports, etc.)

Employer (name / adress): _____

If AHV / IV or social welfare office is assuming the cost of treatment: Name / adress: _____

Name / adress of your family doctor / dentist: _____

Do you have supplementary dental insurance? If so, with which insurance company? _____

How did you hear about us?

☐ Referral by: ☐ doctor ☐ dentist Name: _____

☐ relatives / friends / acquaintances ☐ website ☐ advertisement – where? _____

☐ publication – which? _____

☐ Kieferorthopädie Zentrum Bern and its partners in Switzerland and the EU would like to email you offers and information from time to time that my be of interest to you. If you do **not** wish to make use of this service, please tick the box at the left. You can also revoke this consent at any later time.

Health issues

Many diseases can have an impact on dental treatment. By completing this questionnaire, you are providing us with important information about the state of your health and enabling us to tailor treatment to you. **Your information will be treated in strict confidence and is subject to medical confidentiality.**

Reason for consultation: _____

Is your visit due to an accident? If so, date of accident: _____ ☐ Y ☐ N

Special request: _____

Are you currently (or were you recently) receiving medical treatment? ☐ Y ☐ N

If so, why? _____

Have you experienced a hospital stay or accident in the last 5 years? ☐ Y ☐ N

If yes, provide reason / type of injury _____

Do you have a medical card / passport (e.g., due to antibiotic shielding, blood thinning, pacemaker, joint replacement and/or organ transplant)? ☐ Y ☐ N

Do you have (or have you had) hepatitis (jaundice)? ☐ Y ☐ N

Are you HIV positive or suffering from AIDS? ☐ Y ☐ N

Please continue on reverse →

Heart disease:

Endocarditis (inflammation of the inner lining of the heart) ☐ Y ☐ N

Heart valve defects / artificial heart valves ☐ Y ☐ N

Angina pectoris ☐ Y ☐ N

Heart attack ☐ Y ☐ N

Blood pressure too high / too low ☐ Y ☐ N

Cardiac pacemaker ☐ Y ☐ N

Blood disorders:

Anaemia ☐ Y ☐ N

Do you bleed for a long time when injured?

Do you have haemophilia (bleeding tendency)? ☐ Y ☐ N

Are you anticoagulated (blood thinning)? ☐ Y ☐ N

Do you bruise easily? ☐ Y ☐ N

Do you suffer from circulatory problems such as fainting spells? ☐ Y ☐ N

Do you have diabetes? ☐ Y ☐ N

Do you suffer from acid regurgitation, heartburn and/or frequent vomiting? ☐ Y ☐ N

Do you have any allergies? If so, which ones? _____ ☐ Y ☐ N

Are you hypersensitive to injections? ☐ Y ☐ N

Do you suffer from breathing problems (asthma, bronchitis and/or hay fever)? ☐ Y ☐ N

Do you suffer from tension / head or neck pain? ☐ Y ☐ N

Have you ever had rheumatism, osteoporosis, joint problems and/or organ transplants? ☐ Y ☐ N

Do you have artificial joints (hip, knee)? ☐ Y ☐ N

Are you currently taking medication on a regular basis? ☐ Y ☐ N

If so, which medications? _____

Are you satisfied with the condition / appearance of your teeth? ☐ Y ☐ N

If not, what concerns you? _____

Have you ever had problems with previous dental treatments? ☐ Y ☐ N

If so, which ones? _____

Have you ever had a serious jaw and/or facial accident? ☐ Y ☐ N

Have you ever had surgery on or radiation to the mouth and/or lips? ☐ Y ☐ N

Do you smoke? How frequently? _____ ☐ Y ☐ N

Do you drink alcohol on a regular basis? ☐ Y ☐ N

Do you use drugs? ☐ Y ☐ N

If so, which ones? _____

Do you suffer from epilepsy? ☐ Y ☐ N

Do you have any other serious medical conditions? ☐ Y ☐ N

Are you taking the „pill" (oral contraceptive)? ☐ Y ☐ N

Are you currently pregnant? ☐ Y ☐ N

If so, in which week? _____

Were you informed about direct payment? ☐ Y ☐ N

We kindly ask you to notify us of any postponements or cancellations at least 24 hours in advance. Should you fail to provide such notification, we reserve the right to charge you for the appointment not kept. In addition, we refer to our General Terms and Conditions, which are available at www.kieferorthopaede-bern.ch and apply to the contractual relationship between you and us.

I hereby certify that the information I have provided is correct and that I am in agreement with the consent form on the following page.

Place / date: _____ Signature: _____

Processing of personal data

The personal data requested in this medical history questionnaire and the personal data collected on the occasion of the medical treatment (course of illness, health data, X-rays and other images, photos, treatment options, treatments carried out, medical clarifications, etc.) are used for the purposes of medical treatment, invoicing, credit assessment and debt collection. In addition, the personal data may be used to send you offers and information unless ticked above as unwelcome. The personal data will be stored in a patient management system in accordance with applicable legal regulations. Depending upon our contract with you, the legal basis for data processing involves fulfilment of the contract with you, our overriding legitimate interests and/or your consent. We process and store your data only for as long as is necessary in accordance with the purpose of the processing in question or for as long as there remains any other legal basis for doing so (e.g., statutory retention and limitation periods). The data that we retain under our contractual relationship with you are held by us at least for as long as this contractual relationship continues and any limitation periods for possible claims by us remain unexpired or for as long as any contractual retention obligations exist.

Should it be useful for the medical treatment, information and/or documents on previous (dental) medical treatments may be obtained from your previous doctor or dentist. In this respect, you release us as well as the requested doctor or dentist from the obligations of medical and professional confidentiality in accordance with the Data Protection Act.

The party responsible for the collected personal data is the Kieferorthopädie Zentrum Bern AG, with its registered office at Neuengasse 43, 3011 Bern. The employees of the Kieferorthopädie Zentrum Bern AG may access and process this data for the above-mentioned purposes. In addition, the personal data may be disclosed to the following third parties in Switzerland and the EU on the basis of your express consent and, in this respect, you hereby release us from the medical confidentiality obligation and the professional confidentiality obligation pursuant to the Data Protection Act and agree the disclosure of data to the following third parties to the extent set out below:

- To dental and other laboratories, should this be necessary for medical treatment;
- To other physicians, health care professionals and medical institutions if you ask us to do so or if they request us to do this on your behalf;
- To health, accident and other insurance companies as well as authorities or government institutions where necessary for medical treatment, billing or invoicing;
- To external IT service providers for support of our software and hardware;
- To other companies and clinics of the Kieferorthopädie Zentrum Bern AG and/or to external service providers for their support in connection with invoicing, administrative activities, credit assessment and debt collection; your personal data, in particular your creditworthiness data, will also be passed on to specialised service providers for the purpose of credit assessment and the maintenance of corresponding databases; furthermore, this credit assessment is based on automatic processes and decisions, and it can have an impact on the availability of payment methods;
- To service providers (e.g., attorneys and debt collection agencies) and authorities (e.g., supervisory authorities, debt enforcement and bankruptcy authorities, justices of the peace, courts) providing support in connection with our collection of debts;
- To MF Group AG in St. Gallen for the purpose of settlement (including assignment of the claim), credit assessment and assertion of the claim as well as to its financing partner in Germany for the purpose of onward transfer and assertion of the claim; your personal and/or creditworthiness data will also be passed on to specialised service companies for the purpose of credit assessment and maintenance of corresponding databases;
- To external partners for the purpose of sending you offers and information unless ticked above as unwelcome.

In the event that personal data are disclosed to a third party in Switzerland or the EU, disclosure is limited exclusively to data required to achieve the corresponding purpose.

You have the right to obtain information concerning the processing of the personal data concerning you and in particular to request correction and/or deletion of the data. In cases where data processing is based on your consent, you also have the right to revoke your consent at any time with future effect. This right has no effect, however, on the lawfulness of the data processing carried out on the basis of your consent up to the point where this consent is revoked. You also have the right to enforce your claims in court or to file a complaint with the competent data protection authority. The competent data protection authority in Switzerland is the Federal Data Protection and Information Commissioner (http://www.edoeb.admin.ch). Should you have any questions concerning data protection, please contact info@kieferorthopaede-bern.ch.