ZAHNARZTPRAXIS
Dental Lounge
THEATERSTRASSE

MEDICAL HISTORY QUESTIONNAIRE & CONSENT FORM

PLEASE FILL IN USING BLOCK CAPITALS

Patient no.: _____

Personal data

Last name: _____ First name: _____

Street address: _____ Postal code / city: _____

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

Gender: M ☐ F ☐ D ☐

Legal representative: _____

Home phone: _____ Mobile phone: _____

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: _____

If applicable, specify health insurance / accident insurance: _____

What is your policy number? _____

The following person may receive information about me and my illness(es):

Name: _____ First name: _____

Street address: _____ Postal code / city: _____

Home phone: _____ Mobile phone: _____

How did you hear about us?

☐ Referral by: ☐ doctor ☐ dentist Name: _____

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

☐ publication – which? _____

☐ Praxis Theaterstrasse 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.

We kindly ask you to notify us of any postponements or cancellations at least 24 hours, operation dates at least 48h, in advance. Ansonsten behalten wir uns vor, den nicht eingehaltenen Termin in Rechnung zu stellen. In addition, we refer to our General Terms and Conditions, which are available at www.zahnarzt-dental-lounge.ch and apply to the contractual relationship between you and us.

Please continue ro reverse ➔

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PLEASE MARK WITH A CROSS OR FILL IN FREE TEXT

Health issues

Your information will be treated in strict confidence and is a subject to medical confidentiality.

1. Your **profession**? _____

2. Have you been medically treated recently? Due to which type of illness? _____ ☐ Y ☐ N

3. Do you take any **medication** (please include recent intake of eg aspirin)? _____ ☐ Y ☐ N

4. Do you have a cold at present? ☐ Y ☐ N

5. Did you have diarrhea or did you vomit during the last 4 weeks? Do you have an infection at present? ☐ Y ☐ N

6. Previous surgery or invasive examinations? _____ ☐ Y ☐ N

7. Did you or one of your relatives experience anesthesia related problems? If yes, please specify _____ ☐ Y ☐ N

8. Did you receive a blood transfusion or a related medication in the past? ☐ Y ☐ N
   If yes, was there a problem? _____

9. Do you have or did you have illnesses of the organs mentioned below:

Heart / circulation ☐ Y ☐ N
Heart attack, angina pectoris, heart disorder, shortness of breath under exercise, inflammatory heart disease, high or low blood pressure? or: _____

Bloodvessels ☐ Y ☐ N
Varicosis, thrombosis, perfusion problems in the legs? or: _____

Airway / lung ☐ Y ☐ N
Asthma, chronic bronchitis, emphysema, tuberculosis? or: _____

Liver disease ☐ Y ☐ N
Yellow skin, hepatitis, fatty liver? or: _____

Kidney ☐ Y ☐ N
Kidney function disorder, kidney infection? or: _____

Esophagus / stomach / gut ☐ Y ☐ N
Gastric ulcer, intestinal inflammation? or: _____

Endocrine disorders ☐ Y ☐ N
Diabetes, gout? or: _____

Thyroid gland ☐ Y ☐ N
Hypo-/hyperthyreosis? or: _____

Eye diseases ☐ Y ☐ N
Elevated eye pressure? or: _____

Nerves / psychological disorder ☐ Y ☐ N
Seizures, epilepsia, depression, paralysis

Diseases of skeleton ☐ Y ☐ N
Spine disorder, joint disorder, frozen shoulder? or: _____

Muscle disorder ☐ Y ☐ N
Is there a history of **muscle disorders** in any of your relatives

Blood disorder ☐ Y ☐ N
Coagulation disorders, leucemia? or: _____

Allergies ☐ Y ☐ N
Pollen, medication, penicillin, wound dressings, latex, sugar, Iodine, nickel?

Any other disease or disorder which has not been specified yet? ☐ Y ☐ N
If so, which? _____

10. Do you need sleeping pills or sedatives regularly? If so, which? _____ ☐ Y ☐ N

11. Smoking, alcohl, drugs? Please specify substance and daily amount _____ ☐ Y ☐ N

12. Have you been diagnosed with hepatitis- oder HIV infection? ☐ Y ☐ N

13. Do you have a hearing disorder? Do you have a hearing aid / implant? ☐ Y ☐ N

14. Do you have osteoporosis? ☐ Y ☐ N

15. Female patients: Are you pregnant? ☐ Y ☐ N

Remarks: _____

I hereby certify that the information I have provided is correct and that I am in agreement with the consent form on page 3.

Place/Date: _____ Signature: _____

MEDICAL HISTORY QUESTIONNAIRE & CONSENT FORM

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 Zahnarztpraxis Theaterstrasse AG, with its registered office at Theaterstrasse 18, 8001 Zurich. The employees of the Zahnarztpraxis Theaterstrasse 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 Zahnarztpraxis Theaterstrasse 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@zahnarzt-dental-lounge.ch.