PERFECT SMILE RAGAZ

MEDICAL HISTORY QUESTIONNAIRE & CONSENT FORM

PLEASE FILL IN USING BLOCK CAPITALS

Patient no.: _____

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Personal data

Last name: _____ First name: _____

Street address: _____ Postal code / city: _____

Home phone / mobile phone: _____ Email: _____

Date of birth (DD/MM/YYYY) __ __ . __ __ . __ __ __ __ Legal representative: _____

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

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: _____

Are you currently (or were you recently) receiving medical treatment? ☐ Y ☐ N
If so, why? _____

Are you currently taking medication on a regular basis? ☐ Y ☐ N
If so, which medications? _____

Have you been taking blood thinners in the last few weeks? ☐ Y ☐ N

Are you hypersensitive to injections? ☐ Y ☐ N

Do you suffer from any of the listed conditions, or have you experienced any of them? ☐ Y ☐ N
Aasthma, bronchitis, hay fever and/or other allergies? _____

Heart problems / heart disease? ☐ Y ☐ N
If so, which? _____

Do you have a pacemaker or joint prostheses? ☐ Y ☐ N

Diabetes (diabetes mellitus)? ☐ Y ☐ N

Kidney problems? ☐ Y ☐ N

Thyroid disorders? ☐ y ☐ N

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

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

Have you ever had rheumatism, osteoporosis or joint problems? ☐ Y ☐ N

Do you bleed for a long time when injured? ☐ Y ☐ N

Do you have a health risk passport (blood thinning, endocarditis)? ☐ Y ☐ N

Do you suffer from another condition not listed here? ☐ Y ☐ N

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

Do you receive supplementary benefits or support from social services? ☐ Y ☐ N

For women: Are you currently pregnant? ☐ Y ☐ N

Please turn →

We kindly ask you to notify us of any postponements or cancellations at least 24 hours in advance. Otherwise, we reserve the right to charge you for the missed appointment.

I hereby declare that the information provided is accurate. I agree that data, including X-rays and photos, may be provided for medical, legal, and financial purposes upon request by the relevant party.

I hereby consent to the disclosure of data to the following third parties to the extent specified below:

- To external IT service providers for support of our software and hardware;
- 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;
- 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 praxis@perfectsmile-ragaz.ch.

Place / date: _____ Signature: _____