Prof. Dr. Gonzales

Questionnaire / new patient

Dear patient

Your physical condition, illnesses or even medication can have an impact on dental treatment. Therefore we ask you to read the given questions carefully and to fill them out truthfully. If you have questions, we gladly help you.

All information provided on your part is subject to medical confidentiality and the current provisions on data protection. This document is therefore only used to adapt the treatment to your health situation and is not intended for third parties.
If you are not satisfied with the following information, please contact us and we will be happy to help you.

Surname; First name

Date of birth

Road; House number

Post Code; place

Telephone (landline / mobile)

Business phone

E-Mail

Profession / employer

Name of the health insurance company

Insurance type

□ legally insured

□ Eligible to aid

□ private - not in the basic tariff

□ Supplementary insurance

□ private - in the basic tariff

□ ________________

If you are not the payee / invoice recipient, then please check out:

Surname; First name

Date of birth

Road; House number

Post Code; place

Declaration of consent for the treatment of minors

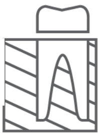
If the patient has not yet reached the age of 18, the consent of the legal guardian is required for treatment:

____

Place; date

____

legal guardian



Information about your current state of health:

Cardiovascular diseases	Yes	No	
Allergies / intolerances	Yes	No	
If yes, which?	___________________		

Infectious diseases:

HIV	Yes	No	
Hepatitis B	Yes	No	
Hepatitis C	Yes	No	
Tuberculosis	Yes	No	
other			_______________________

Other diseases:

Coagulation disorders	Yes	No	
Asthma	Yes	No	
Epilepsy	Yes	No	
Diabetes	Yes	No	
Renal dysfunction	Yes	No	
Gastrointestinal disease	Yes	No	
Thyroid disease	Yes	No	
Cardiovascular problems	Yes	No	
Migraine	Yes	No	
Prostate disease	Yes	No	
other			___________________
Other health risks	Yes	No	______________________

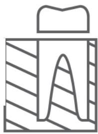
General Information:

Regular medication	Yes	No	Which? ___________________
Smoking	Yes	No	How many? ___________________
Drugs	Yes	No	Which? ___________________
Previous X-ray examinations	Yes	No	If so, when? _____________
Pregnancy	Yes	No	If yes, which month? __________

____
Referring doctor - name; Address; Phone number. - (if available)

____
Family doctor - name; Address; Telephone number

Frauenplatz 11, 80331 München
Tel.:089 / 23 23 87 28 0
zahnarzt-gonzales-muenchen.de
info@prof-gonzales.de



Why are you getting treatment?

Do you have a toothache?	Yes	No
Do you have any noise or pain in the temporomandibular joint?	Yes	No
Do you sometimes feel pain?	Yes	No
Does your gum retreat?	Yes	No
Are your teeth loosened?	Yes	No
Have you had an X-ray examination in the past 12 months?	Yes	No
Would you like to be informed about artificial teeth (implants)?	Yes	No
Do you find the appearance of your teeth a problem?	Yes	No

How did you find out about our practice?

□ Internet
□ Magazines
□ Acquaintance
□ other:

____

Do you want to be added to the e-mail distribution list? Yes No

I undertake to inform the practice immediately of any changes.

I hereby consent to the storage of my personal data.

I hereby confirm with my signature that I have read and understood the information.

______________________ ____

Place; date Signature patient (debtor / legal guardian)

Prof. Dr. Jose Gonzales
Spezialist für Parodontologie

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General Data Protection Regulation

Dear patient,

Your personal data has always been important to us medical professionals. It is not for nothing that we doctors have long been subject to very strict professional confidentiality. This means that a doctor generally does not pass on any information to anyone.
Of course there were and are exceptions that have long been regulated by law.
Data protection experts have now brought the EU GDPR for short with the "European General Data Protection Regulation". We therefore ask you to observe and sign the following points:

1 . Data protection
You have taken note of the data protection declaration, which is posted in practice in the waiting room. Our team will be happy to answer any questions you may have.

2. Note on e-mail traffic
Practice sends and receives e-mails with transport route encryption (SSL / TLS). We also recommend using SSL / TLS. Content encryption does not take place.
Due to the technology, it cannot be ruled out that an email will be intercepted. It is not reached or manipulated. Since this is not in our power, we cannot accept liability.

3. Doctor-patient contact - advice and diagnosis
Do you agree that the practice will contact you?

Telephone number (s): ______________________________________

Fax under fax number: ______________________________________

Email at: ______________________________________

4. Doctor-doctor contact - treatment data and diagnosis (§73 Abs. 1b SGB V):
Do you agree that the practice requests treatment data, findings and diagnoses from other doctors, service providers, nursing facilities, hospitals treated to you or transmits them to them?

□ Yes
□ No

□ by post □ by fax □ via phone □ by E-Mail

5. Doctor-laboratory contact - diagnosis (§73 Abs. 1b SGB V)
Do you agree that the practice transmits your name, first name, date of birth, patient number to the laboratory commissioned by us for the purpose of diagnosis and billing?

□ Yes
□ No

Remember that we cannot offer laboratory services without your consent.

6. Invoice
You are informed that we are obliged to submit billing data for statutory insured patients to KVB for the purpose of financial compensation.
You are informed that we will transfer your billing data to our billing and collection service EOS Health AG and you agree to this.

□ Yes
□ No

Please keep in mind that we cannot act for you without your consent.

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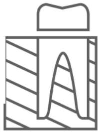

7. Change of doctor
Do you agree that a transfer of your patient files takes place between your previous doctor and the new doctor, regardless of whether we request data or transmit data?

□ Yes
□ No

8. Confidant
If you would like us to provide information to your confidants such as B. Spouse, children, please name them to us:

____

____

____

9. Rights
Of course, we will correct your data if you point out an error to us.
We delete data according to legal regulations. We are required to keep patient records for 10 years, in some cases even 30 years if you have been X-rayed.

Place, date, signature of the patient

____

____

Patient name: _________________________

Patient number.: _______________________

BMV-Z § 8 paragraph 4
As long as a valid insurance card / certificate is not presented, the dentist may request private remuneration for the treatment. If the valid insurance card / certificate is submitted within 10 days of the first claim, the statutory health insurance can be billed via the insurance card.

Treatment appointments agreed with you will be kept by us for you personally to ensure optimal treatment. This applies to both dental treatments and prophylaxis. In the event of missed appointments or cancellations less than 24 hours before the agreed start of treatment, we reserve the right to charge an appropriate cancellation fee. Please let us know in good time if you cannot appear on an agreed date.

I hereby confirm the accuracy and completeness of the above information and health issues.

___________________________ ___________________________
Place and date signature

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