JAKOB GRALL

ZAHNARZT

Welcome!

We are delighted that you want to maintain your smile and dental health with us.

In order to adapt your visit to your needs and wishes and to get to know you better, we kindly ask you to answer the following questions completely. All information is subject to medical confidentiality and strict data protection regulations. If you have any questions, we are here to help you.

Name, First Name ____________________ date of birth ____________________

Street ____________________ Postal code, city ____________________

Phone (private/business) ____________________ Mobile ____________________

Email ____________________

Occupation ____________________ Employer ____________________

Insurance:

- o Legally insured
- o Privately insured
- o Privately insured in basic tariff
- o Additional insurance
- o Entitled to government support

Name of Health Insurance: ______________________________

How did you hear about our practice? ______________________________

For family insurance: The data of the main insured person is as follows:

Name, First Name ____________________ date of birth ____________________

Street ____________________ Postal code, city ____________________

Please turn page

Health Questionnaire

Cardiovascular Diseases: ☐ yes ☐ no

If yes, which: ____

Infectious diseases

Hepatitis ☐ yes ☐ no If yes, which type: ____________________

HIV ☐ yes ☐ no

Tuberculosis ☐ yes ☐ no

Other: ____

Other diseases

Blood clotting disorders ☐ yes ☐ no

Asthma / lung disease ☐ yes ☐ no

Rheumatism / rheumatic fever ☐ yes ☐ no

Kidney diseases ☐ yes ☐ no

Diabetes ☐ yes ☐ no

Epilepsy ☐ yes ☐ no

Other: ____

Allergies, intolerances: ☐ yes ☐ no

If yes, please specify: ____

(e.g. medication, latex, household cleaners)

Other Information

Regular medication ☐ yes ☐ no

If yes, which: ____

Previous x-ray examination (teeth, jaw and facial area) ☐ yes ☐ no
if yes, when ______________________________

Smoking ☐ yes ☐ no

Pregnancy ☐ yes ☐ no

Name, Address of General Practitioner: ____

Do you suffer from morning headaches/tension in the neck and throat area? ☐ yes ☐ no

Have you received orthodontic treatment? (Braces) ☐ yes ☐ no

Please turn page

Further Information

Preferred Correspondence via:	☐ Mail	☐ Email		
Preferred Appointment reminders via:	☐ Phone	☐ Email	☐ SMS	☐ none

If you need to cancel an appointment, please do so at least **24 hours before the scheduled treatment**. By signing, you agree to bear the corresponding cancellation fee even without treatment, currently 45, - euros per half hour.

I hereby confirm that I have read all the information and that the information I have provided is correct and complete:

______________________________	______________________________
Place, Date	Signature Patient or legal representative

JAKOB GRALL

ZAHNARZT

Data Protection - Basic Regulation

Declaration of consent for data processing according to DS-GVO:

We inform you about your data subject rights according to the DS-GVO.
As a data subject affected by data processing, you can assert the following claims:

You have a right to information from our practice as to which of your personal data is processed by us. You also have a right to rectification, erasure and restriction of processing, as well as a right to object to data processing and a right to data portability.
If the data processing is based on your consent, you have the right to revoke this consent.

Please note that the data will only be processed for the purpose mentioned below. Should the personal data collected from you be further processed for another purpose, we will inform you of this separately and notify you of this change of purpose.
In the event of a revocation, your data will be deleted after the expiry of legal deadlines with the receipt of a written declaration of intent.

*I hereby consent to the practice of Jakob Grall collecting my data for the following purposes:
for the maintenance of contact data, the fulfillment of the treatment contract, for the billing of services rendered as well as for the therapeutic documentation. To request treatment data and findings concerning me from other doctors, dental laboratories, insurance companies for the purpose of documentation, invoicing and further treatment. The practice is also authorized to transmit treatment data and findings concerning me to other doctors treating me.
this also applies to insurance companies.*

Patient information on data processing in our practice

In the course of treating patients, we collect data in our practice about you, your
your insurer, and on your state of health.
This data is handled in accordance with data protection regulations.

The following information will give you an overview of the data we collect and how we handle it.
we collect and how we handle it.

If you have any questions, please feel free to contact us at any time.Responsible for data protection in our practice is:
Zahnarzt Jakob Grall, Tel.No.: 089 / 21530080, Mail: kontakt@zahnarzt-grall.de

Type of data collected:
Name, address, telephone, mail, insurance, health data (medical history, allergies, findings), case-related treatment data (medical histories, diagnoses, images, movement data, therapy suggestions, findings that we or other doctors collect).

Purposes of data processing and legal basis for processing:
Treatment documentation, billing, recall, scientific work and professional publications,
Data exchange with the referring and external practice, dental laboratory, Association of Statutory Health Insurance Dentists, insurance companies.
The legal basis arises from Art. 6 para. 1 letter b. Ds-GVO (fulfillment of a contract).

Recipients of the data:
Referring practice, dental laboratory, third-party practice, Association of Statutory Health Insurance Dentists, insurance companies.
In addition, legal reporting obligations arise from the Infection Protection Act, the RöV,
the Radiation Protection Ordinance, the Narcotics Act and the Child Protection Act.
children.

Duration of data storage and deletion periods:
The data of the patient file as well as the X-ray images are stored for min.10 years according to §630 f Abs. 3 BGB.
In addition, the data will be deleted when they are no longer needed to fulfill the above-mentioned purposes.

I have read and understood the patient information and declaration of consent for data processing according to DS-GVO. It can be handed over to me on request. I also consent to my image and/or movement data being used in strictly anonymous form for scientific work and/or specialist publications in accordance with the provisions of the GDPR

Munich, the _______________________

Name in block letters: ____________________________ Signature:__________________________