IMPLANT COMPETENCE CENTER

We welcome you to the clinic group practice of implantology, peridontology und aesthetics Dr. Cacaci & Dr. Randelzhofer!

We would like to treat you in the best even possible medical and personal manner. Therefore we kindly ask you to fill in the following questionnaire. This is important for an adequate and risk-free medical treatment. Your given information is protected of the medical confidentiality (§ 203 StGb) and the provisions of the data protection.

Patient
Mr./Mrs./child

last name | first name | date and place of birth

member

last name | first name | date and place of birth

address

street | no. | zip code | city | country

phone

phone daytime / business | phone private

mobil phone | e-mail

profession | employer

Health insurance company

How did you hear about us?

- Private recommended ☐ by whom? ----------
- Focus implantology list ☐
- Referral doctor ☐ doctor´s office: ----------
- Internet ☐

Important information!

The implantology consultation:

The implantology consultation for panel patients is a private medical service. This is not covered by statutory health insurance. About this consulting service, you will receive an invoice for the fee schedule for dentists (GOZ), usually this is 90-160 euros (depending on complexity).With your signature you confirm that you have been informed about this.

Photo documentation:

Most treatments are photographed by us cause of quality assurance reasons. With your signature you agree with the use of the images for professional purpose.

Organisation of our clinic office:

We always make every effort to avoid long waiting times. Therefore, we ask you to cancel your appointment at least 24 hours before. In addition, you will receive (at least 1 day) prior to your appointment a confirmation SMS, e-mail or a phone call.

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Medical consultation: Have you been in medical/dental treatment lately? ☐ no ☐ yes

If so, why? ----------

Family doctor / dentist: Name, address or phone: ----------

Medication: What medical drugs do you take regularly?

Very important!!!
Do you smoke? ☐ no ☐ yes
If so, about how many cigarettes a day? ----------

Do you take or have you ever taken **bisphosphonates** (for example Didronel**,** Bonefos, Aredia, Fosamax, Bondranat, Acetonel, Skelid, Bonviva, Ostac, Zometa or other) after a tumor disease or as a osteoporosis therapy.?

☐ no ☐ yes ☐ don´t know ☐ per infusion

Do you take any blood thinning medication? ☐ no ☐ yes which: ----------

Do you have artificial joints? ☐ no ☐ yes which: ----------

Allergies: Do you have an allergy identification? ☐ no ☐ yes
Are there any allergy tendencies (hypersensitivity)?

Cardiac disease:
Heart disease (insufficiency)? ☐ no ☐ yes
Angina pectoris? ☐ no ☐ yes
Cardiac pacemaker, heart valve replacement? ☐ no ☐ yes

Have you ever had a heart attack? If so, when? ---------- ☐ no ☐ yes

Other: ----------

Circulatory disorder:
Hypertension? ☐ no ☐ yes
Hypotension? ☐ no ☐ yes

Metabolic disease:
Diabetes mellitus? ☐ no ☐ yes
Gastro-intestinal-desease? ☐ no ☐ yes
Thyroid-desease? ☐ no ☐ yes

Nervous system disorder:
Epileptic seizures ? ☐ no ☐ yes
Seizures? ☐ no ☐ yes

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Blood desease:	Bleeding disorder (haemophilia)?	☐ no ☐ yes
Infectious diseases:	Liver inflammation / jaundice (hepatitis A / B / C)?	☐ no ☐ yes
	Tuberculosis?	☐ no ☐ yes
	Chronic desease tract infection, coughing etc.?	☐ no ☐ yes
	Are you HIV-positive?	☐ no ☐ yes
Others:		
	Stroke?	☐ no ☐ yes
	Raised intraocular pressure?	☐ no ☐ yes
	Pregnancy?	☐ no ☐ yes
	If yes, in which week? ----------	

Do you have any other deseases? Which ones?

Additional informaion:	Are you addicted to drugs or alcohol?	☐ no ☐ yes
	Do you take tranquiliser or stimulant?	☐ no ☐ yes

X-ray: Have you been x-rayed in the head or jaw area last year? ☐ no ☐ yes

If yes, Doctor´s office: ----------

Address: ----------

What can we do for you? What afflictions do you have? ----------

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What expectations do you have on us? ----------

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place date signature patient

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Important notes to your data protection and data security

Patient
Mr./Mrs./child ----------

last name first name

address ----------

street no. zip code city country

e-mail ----------

mobilephone ----------

The confidentiality of your personal data is very important to us. We assure you that your personal data will be treated with the extraordinary dilligence. Data will never be passed on to third parties.

We would like to care for you extensively and according to the latest legal requirements we do need your approval:

Recall / placing of an appointment:
Professionel tooth cleaning and routine check-ups will ensure your oral health. With your signature you agree that we may remind you on upcoming appointments by phone, mail or e-mail/ SMS.

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Consent to the data processing for other purposes:
Further we would like to inform you about medical news, services and events or changes around our doctor´s office. With your signature you agree that we may inform you by mail or e-mail.

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place date signature patient

Of course, you may withdraw your consent to data processing of your personal data at any time by mail or phone without giving any reasons!