

## Registration

Date: \_\_\_\_\_

First name: \_\_\_\_\_

If you are not the insurant yourself, who is it?

Last name: \_\_\_\_\_

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Last name: \_\_\_\_\_

Place of birth: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Adress: \_\_\_\_\_

Landline: \_\_\_\_\_

Cell: \_\_\_\_\_

Billing address:

E-Mail: \_\_\_\_\_

Name: \_\_\_\_\_

Profession: \_\_\_\_\_

Adress: \_\_\_\_\_

Employer, Place: \_\_\_\_\_

Phone at work: \_\_\_\_\_

Health Insurance: \_\_\_\_\_

Are you a beneficiary of the public service?

compulsory insurance : 0 yes

0 yes

0 no

0 no

What is the primary reason for your visit in our dental practice?

Who recommended our practice?

Do you have a dental insurance?

I can also appear at short notice to the appointment. You are welcome to call me.

I would like to receive an appointment reminder by mail.

### **Prophylaxis**

The professional dental cleaning (PTC) is a private service that is not paid by the statutory health insurance.

I would like to participate in your prophylaxis recall system

**When and where was the last X-ray of teeth or jaw?**

time: \_\_\_\_\_  
If radiographs were made within the last 2 years please  
give us the name and address of the dental practice: \_\_\_\_\_  
\_\_\_\_\_

**Please check the appropriate one.**

- | <b>yes</b> | <b>no</b> |                                                      |
|------------|-----------|------------------------------------------------------|
| 0          | 0         | Do you have toothache?                               |
| 0          | 0         | Do you often have headache?                          |
| 0          | 0         | Do you have TMJ pain?                                |
| 0          | 0         | Do you have popping of the temporomandibular joint?  |
| 0          | 0         | Do you have neck pain?                               |
| 0          | 0         | Are you satisfied with the appearance of your teeth? |

**Health questions: Please check the appropriate one.**

- | <b>yes</b> | <b>no</b> |                                                                                               |
|------------|-----------|-----------------------------------------------------------------------------------------------|
| 0          | 0         | Do you have a care degree?<br>If yes, which one? _____                                        |
| 0          | 0         | Have you been receiving medical treatment recently?<br>If so, because of which disease? _____ |
| 0          | 0         | Have you ever had a surgery?<br>If yes, what for? _____                                       |

**Cardiovascular diseases: Please check the appropriate one.**

- | <b>yes</b> | <b>no</b> |                                                          |
|------------|-----------|----------------------------------------------------------|
| 0          | 0         | Heart failure / weakness                                 |
| 0          | 0         | Angina pectoris (heartache during exercise)              |
| 0          | 0         | Myocardial infarction: year? _____                       |
| 0          | 0         | Arrhythmia                                               |
| 0          | 0         | Pacemaker: year? _____                                   |
| 0          | 0         | Heart valve disease, artificial heart valve: year? _____ |
| 0          | 0         | too high or too low blood pressure: value? _____         |
| 0          | 0         | Stroke: year? _____                                      |
| 0          | 0         | endocarditis                                             |
| 0          | 0         | Circulatory disorders                                    |

**Circulatory disorders have you. Please check the appropriate one.**

- | <b>yes</b> | <b>no</b> |                                                                                     |
|------------|-----------|-------------------------------------------------------------------------------------|
| 0          | 0         | allergies<br>If yes, which? _____                                                   |
| 0          | 0         | Allergy pass?                                                                       |
| 0          | 0         | Seizure disorders (epilepsy)?                                                       |
| 0          | 0         | Respiratory diseases? Which? _____                                                  |
| 0          | 0         | Bleeding disorders. Which? _____                                                    |
| 0          | 0         | Glaukoma?                                                                           |
| 0          | 0         | Thyroid disease. Which? _____                                                       |
| 0          | 0         | Do you wear joint prostheses or other implants? _____                               |
| 0          | 0         | Do you have rheumatism or arthritis? <b>Please underline this.</b>                  |
| 0          | 0         | Are you HIV positive?                                                               |
| 0          | 0         | Do you have jaundice / liver inflammation?                                          |
| 0          | 0         | Hepatitis B 0 Hepatitis C 0 other forms? _____                                      |
| 0          | 0         | Do you have tuberculosis?                                                           |
| 0          | 0         | Are you a diabetic?<br>0 diabetes type 1? / 0 Type 2 diabetes<br>other forms? _____ |

**yes no**

- 0 0 Osteoporosis?
  - 0 0 Stomach / intestinal disease?
  - 0 0 Kidney disease?
  - 0 0 Liver disease?
  - 0 0 Tumor disease? Which tumor? \_\_\_\_\_
  - 0 0 Are you pregnant? \_\_\_\_\_ week      date of birth: \_\_\_\_\_
  - 0 0 Do you take medication (which)? \_\_\_\_\_
- 
- 

- 0 0 Have you ever received orthodontic treatment?
  - 0 0 Have you ever taken bisphosphonates (medicament for breast / prostate cancer, osteoporosis)?
  - 0 0 Smoking? If so, how much per day? \_\_\_\_\_
  - 0 0 Former smoker? When stopped? \_\_\_\_\_
  - 0 0 Do you consume narcotics? when, how much and what? \_\_\_\_\_
- 

**Name and address of your general practitioner or your current specialist:**

---

---

**Hamburg, the** \_\_\_\_\_  
digital signature

In our practice, we attach great importance to accurate scheduling in order to avoid annoying waiting times for the patient.

Therefore, please understand that we have to charge 50% of our fixed costs for agreed treatment times you didnt show up or canceled at short notice (less than 24 hours in advance).

For every half hour that you are late we have to charge 90, - Euro. For each appointment for professional dental cleaning you dont show up we have to charge 50 euros.

This amount does not include a dental fee and only covers part of the current operating expenses.

**Hamburg, the** \_\_\_\_\_  
digital signature

I agree that if necessary I will be given a local anaesthesia. I am informed that irritation may occur in the lower jaw and on the tongue in very rare cases (persistent numbness, tingling), which usually disappear again. I am aware that after dental surgery under local anesthesia there is an increased risk of accident if you have active participation in road traffic.

**Hamburg, the** \_\_\_\_\_  
digital signature

## Consent form

Patient / Insured person:

**May we contact you?**

Yes  No

**If yes, how can we do that?**

- post             e-mail             mobile phone             private telephone number  
 fax             business phone number

**On which topics may we contact you?**

- appointment             inquiries from insurance  
 diagnostics             questions from labs  
 treatment planning / arrangements

**Transfer of treatment data to:**

- orthodontist             oral and maxillofacial surgeon  
 external laboratory             physiotherapist             osteopath  
 naturopaths             general practitioner             cardiologist  
 diabetologist             rheumatologist  
 other specialists \_\_\_\_\_

Hamburg, the \_\_\_\_\_

\_\_\_\_\_  
signature

Hereby I give my consent that the practice Dr. med. Heike Meynberg can send my X-ray images encrypted to a further-treated dentist / doctor or request X-rays of pretreatments.

Hamburg, the \_\_\_\_\_

\_\_\_\_\_  
signature

Dear Patient,

As part of your treatment, we need to collect information about you, your insurance status, and your state of health. Of course, this information is managed by our practice with the utmost care.

To give you an overview of the data we are keeping and the data protection of our dental practice, attach the following information:

In our practice is responsible for the data protection and is available for questions:

**Practice owner Heike Meynberg**

**Legal form of our practice: individual practice**

**Practice address: Große Elbstr. 68, 22767 Hamburg**

**Telephone: 040 63 94 00 66**

**Fax: 040 63 94 00 67**

**E-Mail: [info@dr-meynberg.de](mailto:info@dr-meynberg.de)**

We collect, store, use, transmit or delete the following personal data:

- Interested parties and patients of our practice who are natural persons
- All other natural persons, who are in contact with our practice (for example commissioners of patient, legal guardians, employees of legal entities, visitors to our website)

Personal data of you will be collected by us if you contact us e.g. via e-mail or telephone in contact and want to make an appointment for treatment. If you appear for treatment in our practice, we will collect data on your insurance status, health status and therapy. It is about especially sensitive data. Furthermore, data will be processed for billing the services provided.

We process the following personal data:

Personal data (e.g., first and last name, address, date and place of birth, e-mail address, telephone number, insurance status); Health data (anamnesis, medical findings, therapy)

We store only information about children if the legal guardian is patient of our practice.

In the case of billing your treatment, your statutory health insurance and the responsible Dentistry Association will receive the necessary treatment data. If you are privately insured, your private health insurance will only receive data if you specifically ask us to submit your data to the insurance. Due to legal inspection obligations, the dentist must be obliged to send x-rays to the Dental Office for examination by the competent authority.

If you would like to arrange an appointment for treatment by e-mail or our other contact form or send us a question, we will store the data you have provided (your e-mail address, your name and your telephone number if necessary) to give you a treatment appointment assign or answer the request. The in this context any collected data will be deleted if any data arising after the storage is no longer required, or restrict processing if there are statutory data retention requirements (legal basis is Art. 6 (1) (1) (b) GDPR).

To treat you in the context of the contract of dental care or a private dentist

treatment relationship and to bill these services to the Dentistry Association or you as a private patient we need to process your personal and health information. Legal basis of this data processing

is thus the processing of data for the purpose of fulfilling practical treatment contracts or for carrying out pre-contractual steps for these treatment contracts (Article 6 (1) (b) DSGVO), the fulfillment of statutory documentation obligations (Article 6 (1) c DSGVO ) and in connection with the enforcement of debts (Article 6 (1) lit. DSGVO). We store your data processed in connection with the treatment relationship in accordance with the legal requirements of the German Patients' Rights Act (BGB) and the Professional Code as well as the Tax Code for a minimum of 10 years. Obtaining evidence of legal disputes within the legal framework 'legal provisions of limitation' can result in a retention of more than 10 years on the basis of the civil law of limitations of up to 30 years, whereby the regular limitation period is three years. It is possible, that we have to store your data up to 10 years.

Processing of personal and health data of patients for the purpose of patient information as part of a

Recall system for dental prevention (legal basis in accordance with Art. 6 Abs. 1 lit. a DSGVO)

You have the following rights with respect to the personal data concerning you:

- Right to information,
- Right to rectification or cancellation,
- Right to restriction of processing,
- Right to object to the processing,
- Right to data portability.

You have the opportunity to complain to us about the processing of your personal data by us:

The Hamburg Commissioner for Data Protection and Freedom of Information,  
Klosterwall 6 (Block C),  
20095 Hamburg,  
Tel .: (040) 428 54 - 40 40,  
E-fax: (040) 4 279 1181,  
E-Mail: mailbox@datenschutz.hamburg.de

Hamburg, the \_\_\_\_\_

\_\_\_\_\_  
signature

**You can either print the form and add date and signature in Dr. Meynberg's office or send it by email to [info@dr-meynberg.de](mailto:info@dr-meynberg.de)**



print it



send it