REGISTRATION FORM

LOVE YOUR SMILE by HF

Welcome to LOVE.YOUR.SMILE. by HF. It´s good to see you at our practice!

As a practice for Dental-Aesthetics we create not only a perfect Dental-Aesthetic, we also create a healty smile for you. All Treatments are executed or supervised by our Dentists, so you can always be sure of perfect results.

Good to know: Some of our Treatments, are paid by your Health-Insurance and with our supplementary dental insurance, your professional dental cleanings are paid to 100% ! Before we start with your Treatment, please be so kind and answer some important questiones. Thank you.

INFORMATION ABOUT YOU

Last Name, Name : _____

Date of Birth : _____ Birthplace : _____

Street : _____

ZIP-Code : _____ Place : _____

Occupation : _____

Mobile : _____

E-Mail : _____

INFORMATION ABOUT YOUR HEALTH INSURANCE

O Statutory O Private

_____
Name of Insurance

INFORMATION ABOUT YOUR SUPPLEMENTARY DENTAL-INSURANCE

O present O not present

_____
Name of Insurance

HOW COMFORTABLE ARE YOU WITH YOUR SMILE?

1 2 3 4 5 6 7 8 9 10

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NEWSLETTER

You are interested in useful informations about Dental-Health? We would be happy to inform you with our monthly Newsletter by e-mail.

O Yes O No

INFORMATIONS ABOUT YOUR HEALTH STATUS

Do you have or have had any oft he following diseases?

O Severe shortness of Breath
O Diabetes
O Epilepsy
O Thyroid Disorders
O HIV- Infection
O Stroke, if so, when _____
O Problems to fall asleep or staying asleep
O Heart attack, if so, when _____
O Liver Diseases
O Paralysis, if so, please specify _____
O Do you wear a pacemaker? If so, since when _____
O Alergic Reactions
Which? _____

O Hepatitis O A O B O C
O Rheumatism
O Blood Diseases
O Blood Clotting Disorders
O Tuberculosis (TBC)

O Other Diseases? _____

O Diseases, Problems with:

O Stomach & Intestines
O Heart & Cicle
O Lungs & Bronchi
O Skin & Mucous membranes
O Liver & Pankreas
O Blood Pressure
O Stress
O Joints
O Headaches
O Psyche

DO YOU REGULARLY TAKE ANY MEDICATION?

O Yes, _____ O No

ARE YOU PREGNANT?

O Yes O No

CONSUMPTION OF

Cigarettes	O No	O Yes	How much: _____
Coffee, Tea	O No	O Ja	How much: _____
Narcotics	O No	O Ja	How much: _____
Sleeping PIlls	O No	O Ja	How much: _____

APPOINTMENTS AND CANCELLATIONS

Appointments at LOVE.YOUR.SMILE. by HF are exclusevly reservated for you! If you are not able to make an agreed upon your appointment, we kindly request that you inform us promptly (at least 48 hours in advance). This would then give us an opportunity to reschedule and potentially avoid downtime.

For fixed appointments which you fail to make without notifying us, we will charge a cancellation fee in the amount of 75,00 EUR. However, this does not apply for no-shows which are clearly not your fault.

GENERAL QUESTIONNAIRE TO DETERMINE FUNCTIONAL DISORDERS OF THE TEMPOROMANDIBULAR SYSTEM (TMD, TEMPOMANDIBULAR DYSFUNCTION)

	Yes	No
Do you feel that your bite is not correct?	O	O
Is your lower jaw limited in mobility?	O	O
Do you suffer from pain in your ear and jaw joint region?	O	O
Do you notice any cracking or grating noises while opening or closing your mouth or chewing?	O	O
Do you have tension in your neck and/ or shoulder muscles?	O	O
Do you grate or gnash your teeth?	O	O
Do you suffer fromheadaches or migraines?	O	O
Do you suffer from tinnitus or ringing in the ears?	O	O
Do you have balance problems or dizziness?	O	O
Do you have temperature-sensitive teeth and/ or exposed necks of the teeth?	O	O

COMMUNICATION BY E-MAIL

Less paper already the environment. Therefore, we are happy to communicate with you by e-mail. We ask for your express consent for this, as we cannot guarantee that e-mail communications cannot be viewed by unauthorized third parties, even in compliance with the highest security standards.

I hereby expressly agree to the communication by e-mail. This consent also includes correspondence containing personal health data. I am aware that this correspondence cannot be guaranteed by unauthorized third parties.

_____ _____

Date Signature

DECLARATION OF CONSENT IN ACCORDANCE WITH THE GENERAL DATA PROTECTION REGULATION (GDPR) FOR PERSONAL DATA

The protection of your personal data is important to us. According to the EU General Data Protection Regulation (GDPR), we are obliged to inform you about the purpose for which our practice collects, stores, processes or forwards data.

I agree that LOVE.YOUR.SMILE. by HF - Dr. Hamide Farshi – Poelchaukamp 22 in 22301 Hamburg, collect, store and process my personal data. The data processing takes place on the basis of legal requirements in order to fulfill the treatment contract between you and your dentist and the associated obligations. For this we process your personal data, in particular your health data. This includes anamnesis, diagnoses, therapy proposals and findings that we or other doctors collect. For these purposes, other dentists, doctors or psychotherapists, physiotherapists, speech therapists, etc., with whom you are receiving treatment, can provide us with data (e.g. in ordinations, referrals, doctor's letters, etc.). The collection of health data is a prerequisite for your treatment. If the necessary information is not provided, careful handling cannot take place.

We only transfer your personal data to third parties if this is necessary and permitted by law or if you have given your consent. Recipients of your personal data can primarily be other dentists, doctors or psychotherapists, physiotherapists, speech therapists, dental technicians, the Association of Statutory Health Insurance Dentists, aid agencies, private health insurances, statutory health insurances, experts, the medical service of the health insurance, the dental association and private (dental) medical clearing houses as well Be a tax advisor and the financial administration. The transmission takes place mainly to coordinate dental and interdisciplinary issues relating to your general or your dental health, to bill for the services provided to you, to clarify questions that arise from your insurance relationship.
I am aware that I can revoke this consent at any time without giving reasons for the future by contacting LOVE.YOUR.SMILE. by HF - Dr. Hamide Farshi - by post or by e-mail smile@loveyoursmile-hh.de to inform me of my revocation of the processing of my personal data. We point out that you have the right to information, correction, deletion, restriction of processing, data portability (Art. 15-21 DS-GVO), as well as to complain to a supervisory authority (Art. 77 DS-GVO) .

I hereby confirm that the above information about my state of health is correct and that I have given it to the best of my knowledge and belief. I have understood and agree to the information on this registration form.

_____ _____

Date Signature