MKG
MUND-KIEFER-GESICHTSCHIRURGIE
Bamberg | Haßfurt

MKG Bamberg MVZ GmbH
Hainstraße 18
96047 Bamberg
Tel. 0951-9230125
Fax.0951-9230126

Pat.Nr.:_____

Anamnesis Form

Dear Patient,

Welcome to the MKG Chirurgie Bamberg! We are delighted that you have choosen our doctor's surgery and put your trust in us. First of all we need some overall information on your person as well as your general medical condition, since generalised diseases can also effect the treatment. Please be so kind and fill in this questionnaire, it will be added to your personal patient file. As a matter of course all informations are subject to the medical confidentiality of our practice. If you have questions please do not hesitate to contact us.

Surname / First name _____ Date of birth _____

Street _____ Postal code / City _____

Private / Mobile Phone _____ @ E-Mail _____

Health Insurace company _____ Name of member _____ Date of birth of member _____

Profession:_____ Company _____

For under age persons:
Legal representative: _____ Date of birth: _____

Name and address of insurance:

_____

Billing information addressed if different to above: _____

Other Physiscians who provide treatment

Dentist:_____ Address:_____

General physiscian_____ Address:_____

Are you pregnant? ○ Yes ○ No Week of pregnancy:

_____

Status of Covid-19 vaccination :

O None O 1. Vaccination O 2. Vaccination O 3. Vaccination O Vaccination completed

(14 days since vaccination) O Recovered

Do you suffer from any of following diseases (Please tick box)

Patient has or has had:

Heart disease / Circulatory trouble	○ yes ○ no	Mental disorder/ anxiety states	○ yes ○ no
High blood pressure	○ yes ○ no	Diabetes	○ yes ○ no
Bleeding disorder	○ yes ○ no	Gastro-intestinal disease	○ yes ○ no
Fainting disorder	○ yes ○ no	Rheumatism	○ yes ○ no
Kidney disease	○ yes ○ no	Thyroid Disease	○ yes ○ no

Do you have a pacemaker? ○ yes ○ no

▼ **Please turn over!** ▼

Infection diseeases

Hepatitis ○ yes Type **A** ○ **B** ○ **C** ○ ○ no

Tuberculosis ○ yes ○ no

HIV ○ yes ○ no

Allergies

Asthma ○ yes ○ no

Latex ○ yes ○ no

Allergy passport ○ yes ○ no

Antibiotics ○ yes ○ no

Have you ever suffered from an intolerance to drugs or injections? If yes, to which?

Tumor disease

Chemotherapy ○ yes ○ no

Radiation treatment ○ yes ○ no

Eye diseases

Glaucoma ○ yes ○ no

Cataract ○ yes ○ no

Bone disease

Bisphosphonate treatment ○ yes ○ no

Addictive drugs

Alcohol ○ yes ○ no

Drugs regulary ○ yes ○ no

Do you smoke? ○ yes ○ no

○ less than 10 per day ○ more than 10 per day

Did you undertake a treatment in hospital lately ? ○ yes ○ no

Address clinic_____

Earlier diseases _____

Do you take blood thinners, e.g. (Aspirin / ASS / Marcumar)? ○ yes ○ no

Do you take other drugs ? Which one: _____

When have you been x-rayed lately? _____

Which part of body ? _____

☐ I agree that my treatment data / findings may be transmitted by MKG Bamberg MVZ GmbH to the dentist, family doctor or doctor providing further treatment named by me for documentation and further treatment purposes. Furthermore, I consent to the practice requesting findings from my treating dentist / general practitioner / doctor providing further treatment, insofar as these are necessary for my treatment at MKG. This consent also applies to future treatments.

☐ I declare consent that MKG Bamberg MVZ GmbH or the treating doctor collects, processes and stores my patient and treatment data/findings or the corresponding data of my child or the person cared for in accordance with the EU-GDPR. I also declare consent with transferring the necessary data to the laboratories in the case of laboratory tests and, if required, transferring the data to receivers as described in the GDPR patient information. In particular, the treatment data / findings may be transferred to the family dentist and to further treating doctors for the purpose of further treatment. The declaration is valid to all upcoming treatments as well. The declaration of consent can be revoke at all times.
In order to have more time for our medical treatments and attendance we keep our administrative effort as low as possible therefore we have transferred our billing to our Health AG Partner, Hamburg. We assure you that they process patient data with the utmost care and absolute confidentiality.

☐ I am **NOT** interested in the practice's recall service. Please do **not** remind me regularly (by phone or email) of a follow-up appointment for examination and/or treatment.

I have taken note of the patient information on data protection. They can be found under:
https://kieferchirurgiebamberg.de/patient-information-on-data-protection/

I can revoke the consent given above at any time individually or in total with effect for the future. A short message to the above address is sufficient for this purpose.

Date:_____ Signature:_____

Patient/Legal representative