MKG
MUND-KIEFER-GESICHTSCHIRURGIE
Bamberg | Haßfurt

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

Pat.Nr.:_____ □ Hain □ Kap □ Has

Medical History & Registration Form

Dear Patient,
Welcome to the MKG Chirurgie Bamberg and Hassfurt! Thank you for choosing us.
Please, fill the following questionnaire, as we need some overall information on your person as well as your general medical condition. As a matter of course, all information is subject to the medical confidentiality of our practice.

Surname: _____ Name: _____

Birthday: _____ Health Insurance Company: _____

Street: _____ Postal Code & City: _____

Telephon/ Mobile Phone: _____ E-Mail: _____@_____

Profession: _____ Company: _____

Dentist: _____ Address: _____

General physiscian: _____ Address: _____

For minor patients and patients that have a care representative:

Legal representative: _____ Birthday: _____

Do you have supplementary dental insurance? ○Yes ○ No

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

Do you suffer from any of following diseases (Please tick box)?
Patient has or has had:

Cardiovascular diseases	○Yes ○ No	Mental disorders	○Yes ○ No
High blood pressure	○Yes ○ No	Dental Anxiety	○Yes ○ No
Blood clotting disorders	○Yes ○ No	Gastrointestinal diseases	○Yes ○ No
Respiratory diseases	○Yes ○ No	Rheumatic diseases	○Yes ○ No
Diabetes	○Yes ○ No	Thyroid disorders	○Yes ○ No
Fainting Disorder	○Yes ○ No	Kidney diseases	○Yes ○ No

Infection diseeases

Hepatitis ○ Yes ○**A** ○**B** ○**C** ○ No

HIV ○ Yes ○ No

Tuberculosis ○ Yes ○ No

Allergies

Latex ○ Yes ○ No

Antibiotics ○ Yes ○ No

Other _____

Do you have a heart passport? ○Yes ○ No

Do you have an allergy passport ○Yes ○ No

▼ **Please turn over!** ▼

Tumor disease

Chemotherapy ○ Yes ○ No

Radiation treatment ○ Yes ○ No

Bone disease

Bisphosphonate treatment ○ Yes ○ No

Osteoporosis ○ Yes ○ No

Substance use or consumtion

Alcohol ○ Yes ○ No

Drugs ○ Yes ○ No

Do you smoke ○ Yes ○ No

○ more than 10 per day

○ less than 10 per day

Did you undertake a treatment in hospital lately?
If yes:
Address clinic: _____

Did you undertake a treatment in hospital lately? ○ Yes ○ No

Address clinic: _____

Earlier / other diseases: _____

Do you take anticoagulant (blood thinners) medication? ○ Yes ○ No
(e.g. ASS / Marcumar / Eliquis / Xarelto / Pradaxa etc.)

What other medications do you take? _____

When was the last time you had an X-ray? _____

Consent to data transfer, billing and recall service:

☐ I agree that my treatment data / findings for documentation and further treatment by MKG Bamberg MVZ GmbH may be transmitted to my dentist, general practitioner or any other doctor that might treat me further, if needed. 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 do **NOT** like to make use of 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.

Explanation and notes:

In order to avoid unnecessary waiting time and to be able to treat you with sufficient time, our medical practice is working based on appointment system. Therefore, we kindly ask you to keep your appointment on time. Appointments reserved but not released at least 24 hours in advance will therefore be charged.

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

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