University of Zurich[UZH]

Kleber mit Patientenadresse

Center of Dental Medicine

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CH-8032 Zurich
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www.zzm.uzh.ch

Clinic: _____

Date: _____

Patient information

Gender: ❑ Male ❑ Female	❑ Father / Mother ❑ Legal representative / assistance
Last name:	Last name:
First name:	First name:
Date of birth: Day: Month: Year:	
Profession:	Profession:
Street:	Street:
ZIP code:	ZIP code:
Place of residence:	Place of residence:
Telephone private:	Telephone:
Telephone business:	Health insurer / place
Mobile phone:	Insurance number:
E-mail:	Cost bearer:
Name and address of your dentist:	❑ Self ❑ Social welfare office ❑ Health insurance (KVG) ❑ Asylum seeker ❑ Accident insurance (UVG) / disability insurance (IV) Military insurance (MV) ❑ Supplementary payment: pension & surviving dependants insurance (AHV) / disability insurance (IV) ❑ Other: _____
Name and address of your physician / medical doctor:	

Contact person and telephone number in case of emergencies: _____

Referred by: _____

Have you been treated at our center before? If yes, by whom: _____

Main complaints:

Please give a brief description for the main reason you are seeking treatment / consultation with us: _____

Use of patient data for research, teaching, or publication purposes

- I agree that my X-rays, images, plaster casts, findings and health-related data as well as any extracted teeth and/or samples taken during the course of necessary dental treatment may be used for teaching purposes (further education and training in the field of dentistry) as well as for publications, teaching materials and research, provided that my personal data are **anonymized** or **encrypted** for the latter.
  - In case of **encrypted further processing** the decoding key is managed according to legal requirements for research in humans, in that an employee who is not involved in the research project keeps the key in a safe place, separate from the data and samples. Decoding is only permitted under defined exceptions.
    You have the right to be informed of health-relevant results or can waive this. You can revoke your consent at any time in writing and without giving a reason. In the case of anonymized further processing the data and samples can no longer be assigned to a person, i.e., you can no longer receive any information regarding your health. Your right to revoke consent is also foregone here, as a reference to persons is no longer possible.
  - Handling of health-related patient data and samples is restricted to persons who require these data and samples to fulfil their tasks. Should these persons process encrypted or anonymized data and samples further for research purposes or pass these to third parties (for example, as part of research collaboration with other university institutes), then the law on human research and the directive on human research shall apply (exception: the anonymization of non-genetic personal data for further use for research purposes is subject to the law on information and data protection). The latter is also applicable to the further use of health-related data and samples for teaching purposes.
  - **Refusal of consent or later revocation has no consequences for treatment.**

	Yes	**No**
• I confirm that I have understood this information, that any questions were answered, and that I agree to the further use of my data and samples according to the above-mentioned explanations.	❑	❑
• I would like to be informed of health-relevant results if these can contribute to preventing, determining and treating existing or future expected diseases. *(not possible for anonymized data)*	❑	❑

Place, date, signature (Patient / legal representative – children capable of judgement should also sign please)

▶ _____

Further questions on the back ▶ ▶ ▶

Information on the general health status

Certain common diseases require precautionary measures in dental treatment.
Your information is subject to the professional secrecy of doctors and will be treated confidentially. Thank you!

General medical information to be filled in by the patient

Are you presently taking any medication? If yes, which? _____

Yes	No		
❑	❑	1.	Have you been vaccinated against tetanus? When _____
❑	❑	2.	Have you ever experienced an unusual reaction (allergy, etc.) to injections, medication or dental materials?
❑	❑	3.	Do you have a medical card / pass related to the following: antibiotic pre-medication, blood thinners, transplants, joint replacement, cardiac pacemaker?
❑	❑	4.	Were you examined by a doctor during the last year?
❑	❑	5.	Have you ever been seriously ill and / or treated in a hospital?
❑	❑	6.	Do you bleed easily or for a prolonged time when you injure yourself?
❑	❑	7.	Have you ever had an accident to your face or jaws or did you undergo surgery or radiotherapy in these areas?
❑	❑	8.	Did you ever have an accident involving your teeth?
		9.	Are you presently suffering or have you ever suffered from the following diseases:
❑	❑	a)	Asthma or hay fever?
❑	❑	b)	Shortness of breath upon slight exertion (e.g. stairs climbing)?
❑	❑	c)	Diabetes?
❑	❑	d)	Heart disease?
❑	❑	e)	High / low blood pressure?
❑	❑	f)	Infections (tuberculosis, hepatitis, sexually transmitted diseases, HIV / AIDS)?
❑	❑	g)	Osteoporosis?
❑	❑	h)	Emotional disturbances?
❑	❑	i)	Tumor disease?
❑	❑	k)	Other: _____
❑	❑	10.	Do you faint easily?
❑	❑	11.	Do you frequently suffer from gastric / digestive disorders or do you vomit frequently?
❑	❑	12.	Do you smoke? If yes, how much? _____ For how many years? _____
❑	❑	13.	Do you consume alcohol regularly? If yes, how much? _____
❑	❑	14.	Do you regularly consume soft or hard drugs? Which? _____
			For females
❑	❑	15.	Are you currently pregnant?

Medical confidentiality, data protection, place of jurisdiction and applicable law

- In the case of a dental referral or order placed with external dentists/physicians or dental technicians, the Center for Dentistry (ZZM) may transmit all data necessary for further treatment to the attending dentist/physician or dental technician. If you have been referred to the ZZM by an external dentist/physician, the ZZM may inform the referring dentist/physician in an appropriate manner about the treatment at the ZZM.
- In case of obtaining confirmation of cost coverage, the ZZM may provide the competent health insurance companies or offices (e.g., IV office, social welfare office) with all data necessary for the granting of cost coverage. The address information may be processed for administrative purposes. For billing by the private practices at the ZZM, the billing data may be forwarded to the Doctors Cooperative Society.
- In case of default in payment, I agree that the ZZM can forward the data necessary for debt collection to the respective enforcement and bankruptcy authorities, judicial institutions as well as any debt collection agency or legal counsel retained by ZZM for this purpose.
- I hereby agree that, in order to verify my creditworthiness, the ZZM may access any payment history and address information that has been stored by credit reporting agencies. The personal and address data provided by me will be transmitted to CRIF AG in Zurich to check my identity or creditworthiness. The ZZM does not transmit medical information to credit reporting agencies.
- Swiss Law applies. The exclusive place of jurisdiction is Zurich / Switzerland
- **I confirm the completeness and correctness of the given details.** Any questions regarding this form (state of health, medical confidentiality, data protection, etc.) were clarified for me by the attending dentist.

Place, date, signature (Patient / legal representative – children capable of judgment should also sign please)

▶ _____