

Admission Form



Dear Patient. Welcome to our practice Kurfürstendamm 213. Please fill in this questionnaire in full, so that we can treat you as good as possible, and to get hold of you if need be. We have several surgeons working in these working premises. Please let us know to whom you have been referred to.

- Dr. med. Uwe Sander
 Dr. Eva-K. Essig MSc.

- Dr. Dr. Anthofer & dr. dr. Jaresch

..... Name Surname Date of birth
..... Postcode/ City Street Street No.
..... Telephone private / Mobile Telephone Work E-Mail
..... Employer Profession	
..... Referring Doctor/Dentist Name, Surname, Date of Birth of the Insured	
..... Medical Insurance		

Please take care to answer the questions below as accurate as possible. Your data will be treated confidentially.

Do you/did you suffer from any of the conditions listed below?

Do you tend to faint	<input type="checkbox"/> yes	<input type="checkbox"/> no	Diabetes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Blood pressure	<input type="checkbox"/> normal <input type="checkbox"/> low <input type="checkbox"/> high		Thyroid disease	<input type="checkbox"/> yes	<input type="checkbox"/> no
Heart condition/bypass	<input type="checkbox"/> yes	<input type="checkbox"/> no	Lung condition/Breathing problems	<input type="checkbox"/> yes	<input type="checkbox"/> no
Other?.....			Liver condition	<input type="checkbox"/> yes	<input type="checkbox"/> no
Bleeding	<input type="checkbox"/> yes	<input type="checkbox"/> no	Kidney condition	<input type="checkbox"/> yes	<input type="checkbox"/> no
(Medication: Warfarin? Heparin? Aspirin? etc.)			Condition of nervus system	<input type="checkbox"/> yes	<input type="checkbox"/> no
Infectious disease: HIV	<input type="checkbox"/> yes	<input type="checkbox"/> no	Epilepsie/Stroke	<input type="checkbox"/> yes	<input type="checkbox"/> no
Hepatitis	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> other		Keloid or hypertrophic or pigmented scarring	<input type="checkbox"/> yes	<input type="checkbox"/> no

Any other medical conditions?

Are you currently under any medical or surgical treatment? no yes, because of

Name of your treating doctor/surgeon?

Do you take any medication? no yes, which kind

Do you know of any allergies you might have? no yes, to

Other allergies:

Are you/ have you been treated for osteoporosis (Bisphosphonate*) yes no
 (*Zometa, Aredia, Bonviva, Bondronat, Fosamax, Fosavance, Skelid, Bonafos, Didronel, Diphos,...)
 Did you have any x-rays of your jaws/ teeth taken in the past 12 months? yes no

Are you pregnant? yes no
 Do you smoke? yes no

If for some reason you are not able to keep your appointment with us, please cancel it as soon as possible. We reserve the right to charge patients who do not cancel their appointments with us. Post local or general anaesthesia you are not allowed to drive.

Failure to pay our in voices will results in additional legal cost and should be avoided.



Please note the following:

We kindly ask that you cancel your appointment as early as possible if you are unable to attend. Our patients receive treatment based on fixed appointments to ensure adequate treatment time is available. We reserve the right to claim compensation for both no-shows and late cancellations. Any treatment with local or general anaesthesia may have a negative impact on your ability to participate in traffic. Driving post-treatment should be avoided.

I have read the privacy policy and agree to the storage of my personal data by the joint practices. I was advised that I am entitled to withdraw my agreement at any time in writing or by e-mail to the practices (Art. 7 Abs. 3 DSGVO).

I am aware that the revocation of the consent does not concern the lawfulness of processing of personal data until the revocation (Art. 7 Abs. 3 Satz 2 DSGVO).

I hereby give consent for all personal and medical data stored to be processed by the operating physician staff and shared with attending physicians as they deem appropriate for my treatment. This consent covers all physician and staff of the joint practices Q213.

If you received x-rays from your dentist by email, please send them to us in advance to:

praxis@q213.de

Would you like to receive an appointment reminder by email from Practice Q213 for surgery appointments?

YES NO

E-mail in block letters

Because of the coronavirus situation, we need to ask you a few questions:

1a) Have you been tested for coronavirus in the last few days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
1b) If yes, when _____		
1c) What was the result?	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
2) Have you had contact with a person in the last two weeks where coronavirus infection is confirmed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3) Have you already been vaccinated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3a) If yes, when _____ 1. Vaccination _____ 2. Vaccination _____		
4) Do you currently suffer of...		
cough?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
fever?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
sniffles?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
sore throat?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
taste or smell disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gastrointestinal complaints?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Head / limb pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Berlin, _____
Date

Signature