Dr. med. dent. Massimiliano Sisera
Dorfstrasse 16, 6340 Baar
Fon 041 761 16 44 / Fax 041 761 16 45

www.zahnarzt-sisera.ch

Patient form with declaration of consent under data protection law

All your information is subject to medical secrecy and will be treated in strict confidence.

Last Name:	Name:
Adress:	
Birthdate:	Profession:
Private Phone:	Work Phone:
E-Mail:	
Health Insurance:	AHV No.:
Family Doctor:	**Recommended by:**
For children, legal representative:	

Medical

Are you currently receiving medical treatment?	□ yes	□ no
Do you take medication regularly?	□ yes	□ no
If yes, which:		

Have you ever had or do you have:

Asthma, hay fever or other allergies?	□ yes	□ no
Unusual reactions to injections, medicines, foods?	□ yes	□ no
Difficulty with prolonged bleeding (blood coagulation disorders)?	□ yes	□ no
Heart or circulation problems?	□ yes	□ no
Too high/too low blood pressure (cross out not applicable)?	□ yes	□ no
A cardiac pacemaker?	□ yes	□ no
Other serious disease, e.g. AIDS, tuberculosis?	□ yes	□ no
Hepatitis (jaundice)?	□ yes	□ no
Diabetes?	□ yes	□ no
Epilepsy?	□ yes	□ no
Rheumatism, arthritis, joint swelling?	□ yes	□ no
Liver or kidney diseases?	□ yes	□ no
Eye diseases (glaucoma)?	□ yes	□ no
Gastric or intestinal diseases?	□ yes	□ no
An HIV positive test?	□ yes	□ no
For women: Is there currently a pregnancy?	□ yes	□ no

Do you want to be reminded for a regular dental hygiene appointment?	□ yes	□ no

We kindly ask you to inform us if your data on the questionnaire changes.

The Data Protection Act stipulates that the processing of health data generally requires the express consent of the patient. In order to fulfil this legal requirement, you are required to confirm the following consent by signing it.

I expressly confirm that I consent to the processing of my data, access to this data by the dental practice of Dr. med. dent. Massimiliano Sisera and the forwarding of this data to third parties such as the laboratory, other doctors, pharmacies, insurers and accountants.

I am aware of the possible risks of data exchange of particularly sensitive personal data (possible access by unauthorised third parties via insecure communication channels) as well as my rights and give my consent for mutual contact between my dentist and myself as a patient via the contact information provided above. This also applies to the exchange of data within the practice and for substitutions.

Based on the above statements and any further verbal declarations, I hereby consent with my signature that my personal data may be processed and transmitted in accordance with data protection regulations. Furthermore, I acknowledge that my consent can be revoked in whole or in part at any time without affecting the lawfulness of the processing carried out on the basis of the consent until the revocation. The cancellation must be made in writing. In addition, my request for cancellation will not lead to deletion, as the responsible healthcare professional or practice is legally obliged to retain my data. Therefore, the request for deletion will only lead to the deletion of my data from my treating healthcare professional or practice in justified exceptional cases if the cancellation is confirmed. At the same time, I hereby release my treating healthcare professional from the statutory retention obligation in this case.

Date: Signature: