Please fill in before medical treatment

AllDent ZAHNZENTRUM

surname, first name | date of birth

surname, first name of the insured person (if different from) | date of birth

street/ no. (where you normally and where you are currently living at) | postal code/ place

mobile no. | Email-add

health insurancy | privat insurancy ☐ Postbeamte A / B ☐ Basistarif ☐ Beihilfe ☐ Zusatzversicherung

profession | employer | family doctor

Do you suffer from any of those illnesses?	**yes**	**no**	additional information
1. Heart disease or circulation disorders	☐	☐	.....
2. Infectious disease (e.g. hepatitis, AIDS, HIV, tuberculosis)	☐	☐	.....
3. Inner diseases (e.g. diabetes, coagulopathy)	☐	☐	.....
4. Allergies (even pharmaceuticals)	☐	☐	.....
5. Do you take any pharmaceuticals currently? (which ones?)	☐	☐	.....
6. Any illnesses	☐	☐	.....

7. Are you pregnant?	☐	☐	.....
8. Are you comfortable with the colour of your teeth?	☐	☐	.....
9. Do you smoke? If you do so, how many cigarettes per day?	☐	☐	.....
10. Do you have a ,,Bonusheft"?	☐	☐	.....
11. Do you have a family doctor?	☐	☐	Name:.....

12. Would you like us to remind you of your recall check up´s as recommended by your dental insurance (no charge)? ☐ Email ☐ SMS ☐ Anruf ☐ Nein

13. How did you take notice of AllDent? .....

I expressly agree with: 1. Storage of my data and transfer to third parties for the fulfillment of the treatment contract and the billing of services (for details see notice in the waiting room and www.alldent.de).
2. Duty to notify if the data is changed. 3. Cancellation fee of € 100 will be charged, - for missed appointments or appointments that have not been cancelled at least 24h beforehand 4. Terms and Conditions of Basic / Postal / Travel or Emergency Insurance are not accepted. There is a free calculation according to the fee schedule for dentists. 5. Video surveillance in the reception / hall area.

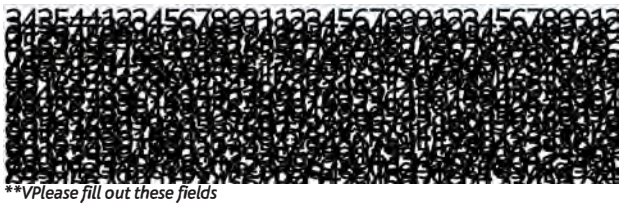
date signature

Thank you very much! Your information will be treated as confidential and are subjected to the medical secrecy.

Consent form*

Surname, first name, address of patient **

Born on**



**VPlease fill out these fields

Legal representative (s) in the case of minors /
legally incompetent people / people with limited competence

First name

Surname Date of birth

Street house no.

Postal code / City

Doctor
(practice stamp/clinic stamp)

Dienstleister mit geprüftem Datenschutzmanagement
TÜVRheinland ZERTIFIZIERT
www.tuv.com ID 0000044064

Dear patient,

We want to focus fully on you and your treatment. This why we have decided to transfer the billing to a competent partner:

BFS health finance

BFS health finance GmbH
Hülshof 24
44369 Dortmund
Tel. 0231-94 53 62-600
Fax 0231-94 53 62-688
patientenservice@meinebfs.de

BFS guarantees the speedy, uncomplicated and accurate processing of your bill. As your friendly and competent partner in all aspects of the billing, it offers partial payment options on request.

In order to enable billing in cooperation with BFS, we require your written consent. We therefore request that you give your consent by signing the adjacent declarations.

Thank you for your confidence.

I confirm my agreement with

- any request by the doctor to the BFS regarding billing through BFS, even before the start of treatment,
- the obtaining of credit information at a credit bureau by BFS (stating the name, date of birth and address of the patient/payer), as far as necessary,
- assignment of claims arising from treatment to BFS,
- further assignment of claims by BFS to the refinancing bank (Landesbank Hessen-Thüringen clearing house)
- transmission of the information necessary for billing and enforcement of claims (eg name, date of birth, address, diagnosis, treatment codes, treatment details and processes) to BFS and possibly to the refinancing bank,
- Temporary use of my data by BFS for testing the development system and optimisating internal billing processes, with subsequent deletion of the data.

I have been informed that BFS will bill me for the services by my practitioner and will claim the invoice amount from me.

If there is a disagreement about the validity of the claim, the medical practitioner may be heard in a possible conflict as a witness.

After the process is complete, the data will be deleted. The statutory retention periods.

Release from confidentiality

I release my medical practitioner, his representatives and BFS from their obligation of confidentiality within the setting described.

The above statements may be revoked in writing with effect for the future.

* Deletions of and/or changes to the foregoing explanations are not permitted and make the consent invalid.