University of Zurich[UZH]

Kleber mit Patientenadresse

Center of Dental Medicine

Plattenstrasse 11
CH-8032 Zurich
Phone +41 44 634 33 11
Fax +41 44 634 43 11
www.zzm.uzh.ch

Clinic: _____

Date: _____

Patient information

Gender: ❑ Male ❑ Female ❑ non-binary	❑ 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: ❑ 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 dentist:	
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: _____

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. Do you bleed easily or for a prolonged time when you injure yourself?

Further questions on the back ▶ ▶ ▶

Yes	No		
❑	❑	5.	Have you ever had an accident to your face or jaws, possibly involving your teeth, or have you ever undergone maxillofacial surgery or radiotherapy?
		6.	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: _____
❑	❑	7.	Do you faint easily?
❑	❑	8.	Do you frequently suffer from gastric / digestive disorders or do you vomit frequently?
❑	❑	9.	Do you smoke? If yes, how much? _____ For how many years? _____
❑	❑	10.	Do you consume alcohol regularly? If yes, how much? _____
❑	❑	11.	Do you regularly consume soft or hard drugs? Which? _____
			For females
❑	❑	12.	Are you currently pregnant?

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

- In the event of a referral or assignment to external specialists (physicians, dentists, dental technicians, prophylaxis assistants, dental hygienists), the private practice may forward all data necessary for further treatment to the assigned specialists (physicians, dentists, dental technicians, prophylaxis assistants, dental hygienists). If you have been referred to the private practice by an external specialist (physician, dentist, dental technician, prophylaxis assistant, dental hygienist), the private practice may inform the referring external specialist about the treatment in the private practice in an appropriate manner.
- In the case of obtaining confirmation of cost coverage, the undersigned agrees that the private practice may forward to the relevant cost payers (e.g. health insurance company, accident insurance company, disability insurance company, social welfare office) all data necessary for granting confirmation of cost coverage. If cost approval has been granted, the invoice will be sent directly to the cost payer, depending on the agreement with the cost payer.
- The undersigned agrees that the private practice may forward the data required for invoicing to the Ärztekasse health insurance fund in Urdorf. Billing is via the Ärztekasse.
- The undersigned agrees that in the case of default in payment, the private practice or the Ärztekasse may forward the data necessary for debt collection to the competent debt collection and bankruptcy offices, court authorities as well as to collection agencies or attorneys commissioned for this purpose, and release the private practice from the obligation of medical (dental) confidentiality to this extent.
- The undersigned agrees that the private practice may request the payment history and address information from the credit reporting agencies for the purpose of credit and creditworthiness checks. For the purpose of checking identity and creditworthiness, the private practice will only provide the credit reporting agency with the personal and address data stated in the “Patient details” section of this form. The private practice does not provide the credit reporting agency with medical information or with payment history data.
- 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, (dental) medical confidentiality, data protection, etc.) were clarified for me by the attending specialist.

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

▶ _____

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Further use of health-related personal data and biological material for research and teaching purposes

Dear patient,

During the course of your treatment at the Center for Dental Medicine (ZZM), health-related data concerning you will be collected and biological material may possibly be taken (e.g., any extracted teeth, saliva samples). This biological material in combination with the data is also of great value for dental research and teaching purposes. We therefore kindly ask for your consent to use this material and your data for research and teaching purposes.

How can you contribute to research and teaching?

By signing with "Yes" on the consent form below, you are providing your health-related data and leftover samples for research and teaching purposes. The consent applies to all data that have already been collected in the ZZM or will be collected in the future. The same applies to the samples.
Your consent is voluntary. It is valid indefinitely unless revoked (withdrawn). You can revoke your consent at any time via the contact address below without providing a reason. After revocation, your data and samples will no longer be made available for new research projects. Your decision will not affect your medical treatment.

How are your health-related data and samples protected?

Your data will be processed and protected at the ZZM in accordance with legal requirements. Only a few individuals are authorized to view the unencrypted data from your medical history and have access to your unencrypted samples. These individuals are responsible for your treatment or have permission to view your data as part of a research project. If your data and samples are used for research projects, they will be encrypted or anonymized as soon as possible. Encrypted means that all personal data such as your name or date of birth are replaced by a code.
The key which reveals which code belongs to which person is kept securely by a person not involved in the research project. Individuals who do not have access to the key will not be able to identify you.
If data and samples are anonymized, there is no key which can be traced back to your person.

Who may use your health-related data and samples?

Your data and samples will be made available to authorized researchers at the ZZM for research projects or may be used in research projects in collaboration with other institutions (e.g., other universities). Projects may be performed in Switzerland or abroad and may include genetic analyses.
If data and samples are passed on in encrypted form to researchers outside the ZZM, the key remains at the ZZM, where it is kept securely by a party not involved in the research project. For research projects abroad, the same data protection requirements apply as in Switzerland at the very least. Research projects are generally subject to a review by the responsible ethics committee.

Further use of health-related personal data and biological material for research and teaching purposes

Will you be informed about research results?
The findings of research projects with data and samples will usually only contribute to improved dental care for future patients. However, if a result is found which is significant for you and a dental measure is available, it is possible for the ZZM to contact you (this is not possible in the case of research with anonymized data and samples).

Will you have financial benefits or disadvantages?
You will not incur any additional costs. It is legally prohibited to generate money from your data and samples. Therefore, there is no financial benefit for you or for the ZZM.

If you still have questions or would like additional information, please use the contact address below or visit our website

https://www.zzm.uzh.ch

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General consent 2022/11_E – Informed consent form

Further use of health-related personal data and biological material for research and teaching purposes

First name and last name of patient

Date of birth

II herewith consent,
that my health-related data (including genetic data) and samples collected or taken during my treatment at the ZZM are available for research and teaching purposes.

❑ Yes ❑ No

I am aware that
– the provisions for the further use of my data and samples are described on the «General Consent Information Sheet 2022/11_E». I have read and understood this information.
– my personal data are protected.
– my data and samples can be used in national and international projects, within public and private institutions.
– my samples can be used for research and teaching purposes for genetic analyses.
– I can be contacted if information relevant to me is found.
– my decision is voluntary and does not have any effect on my treatment.
– my decision is valid indefinitely.
– I can withdraw my consent at any time without giving reasons.

Place, date

Signature of patient, being of sound judgement

Place, date

Signature of legal representative, if applicable
(name and reference to patient)

You can receive a copy of this page with signature if you wish.
If you have any questions, please contact your treating dentists or the following contact:

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