

This form must be completed entirely and correctly!

ENG

First Name(s)	:
Lastname	:
Date of birth.	:
Address	:
Zipcode	:
Place	:
Telephone number	:
Email	:
Insurance	:
Policy number	:

Family doctor :

Tel. number :

Previous dentist :

Tel. number. :

Comments :

With this registration form comes a medical questionnaire. This must be completed fully and truthfully

Upon signing, you declare:

- To have read our terms and conditions
- To have filled out the above truthfully

Rotterdam,

Date	:
Signature	:

Name:**Date of birth:**

1. Do you experience chest pain or tightness during exertion (angina pectoris)?	
2. Have you had a heart attack?	
3. Do you have a heart murmur or heart valve defect?	
4. Do you have an artificial hip or heart valve?	
5. Have you undergone vascular surgery in the last 6 months?	
Do you require antibiotics during dental treatment?	
6. Do you experience palpitations without exertion?	
7. Do you suffer from heart failure?	
8. Do you have high blood pressure?	
9. Have you experienced paralysis (stroke or transient ischemic attack) or speech disorders?	
Have you had a stroke or transient ischemic attack in the last 6 months?	
10. Have you ever fainted during dental or medical treatment?	
11. Do you take medication for epilepsy?	
12. Do you experience hyperventilation?	
13. Do you have asthma?	
14. Do you have poor lungs?	
15. Do you have hay fever?	
16. Have you ever had an allergic reaction after taking medication or using medical materials (iodine, rubber, band-aids)?	
Are you allergic to penicillin or antibiotics?	
17. Do you have diabetes?	
18. Have you been diagnosed with an overactive thyroid?	
19. Have you been diagnosed with an underactive thyroid?	
20. Do you have liver disease?	
21. Do you have a chronic kidney disease for which you follow a diet?	
22. Do you have chronic gastrointestinal complaints resulting in a weight loss of more than 5kg?	
23. Do you currently have a contagious disease? Which one? HIV / HEP A / HEP B / HEP C	
24. Do you have anemia with symptoms (tiredness, dizziness)?	
25. Do you have a malignant disease of the lymph nodes or a blood disorder?	
26. Have you been diagnosed with a tendency to bleed?	
27. Have you been irradiated for a tumor or growth in the head or neck?	
28. Are you currently taking medication? -For the heart? -Are you under the care of the anticoagulation clinic? -For high blood pressure? -For diabetes? (insulin) -Prednisone, corticosteroids, or other immunosuppressants? -Medications for cancer or bleeding disorders? -Penicillin or antibiotics? -Sedatives, sleeping pills, antidepressants? -Other medications? -Do you use narcotic substances daily? -More than 5 alcoholic drinks?	
29. Do you smoke? How many?	

Signature and date:

Consent Form

Client information:

Mr/Mrs:

Date of birth:

Legal guardian (if applicable)

I hereby give permission to Tandartsenpraktijk Coolhaven to process data about me and my health for the purpose of providing dental care. This consent includes:

- I. Processing personal data present in my patient file;
- II. Providing my personal data to third parties for the purpose of processing claims;
- III. Providing my personal data to other healthcare providers, to the extent necessary for my treatment.

* For children under 16 years old, it is required that the legal guardian (also) provides consent.

Place.....

Date.....

Signature

Signature legal guardian

(if applicable)

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To provide you with more insight into our procedures, we kindly ask you to carefully read the text below. These are the 'house rules' of the practice. Most of the house rules are self-explanatory.

You must always have a valid identification with you. This also applies to your proof of registration with your health insurance.

You must promptly notify our receptionist of any changes to your personal details.

Appointments:

We work in our practice exclusively by appointment. Appointments can be made by phone or at the reception desk. We will always utilize the reserved time planned for you. However, it may occasionally occur that you have to wait if there is a delay. The delay time cannot be attributed to the dentist/dental hygienist in any way.

Missed Appointments:

If you have made an appointment, we expect you to keep it. In case of hindrance, please cancel/change your appointment at least 24 hours in advance. If you fail to do so in a timely manner, do not show up without notice, or arrive late, we will be obliged to charge for the reserved time.

Pain complaints / emergencies:

Regarding pain complaints/emergencies; if you call before 10:00 in the morning, we will try to assist you the same day. However, you must adhere to the offered treatment time. If you call later in the day, it may be that we cannot assist you on the same day as we have fixed times for emergencies/pain complaints. We cannot accommodate your preferences regarding your work/school in case of pain complaints.

Service / Replacement:

If we are not present, the answering machine will always mention the attending dentist.

Payments:

We have contracts with most health insurance companies, meaning we can directly invoice them. If there is a co-payment, you will receive an invoice from us.

Answering Machine:

If you call us outside of practice hours, you will reach the answering machine. Always listen to it entirely and carefully, as there may be important information for you.

Your belongings:

Take care of your belongings yourself. Tandartsenpraktijk Coolhaven is not liable for damage, theft, or loss of your belongings. It is advised not to leave your belongings unattended. Aggressive behavior, verbal or otherwise, will not be tolerated and will result in immediate deregistration.

Initials for read and understood:

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