TÜV AUSTRIA HELLAS
EN ISO 9001:2008
No. 0217100063529

yiannikos
CENTRE FOR HOLISTIC DENTISTRY

PATIENT HISTORY

PATIENT NAME / SURNAME: ....

OCCUPATION .... **DATE OF BIRTH:** ....

TEL: .... **MOBILE**...

ADDRESS: .... **POSTAL CODE:** ....

E-MAIL: ....**FACEBOOK**..

Please note the circle:

1. Has there been any change in your general health within the last year? ◯ Yes ◯ No
2. Are you presently, or have you been under the care of a physician during the past year? ◯ Yes ◯ No
3. Have you had any serious illness, operation, or been hospitalized within the last 5 years? ◯ Yes ◯ No
4. Are you taking any medicine(s) including non –prescription drugs? ◯ Yes ◯ No
5. Do you have or have you had a problem with alcohol or drug abuse? ◯ Yes ◯ No
6. Do you smoke? ◯ Yes ◯ No

Women only

7. Are you pregnant or is there a possibility that you are? ◯ Yes ◯ No

8. Do you take birth control pills? ◯ Yes ◯ No

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8 Alkeous Street, 1060 Nicosia Cyprus
Tel: +35722764765
Fax: +35722756160
e-mail: info@yiannikosdental.com
url: www.yiannikosdental.com

9. Are you allergic or have you had a reaction (swelling, rash, itching) to:
Please note the circle

- ○ Penicillin or other antibiotic
- ○ Local anesthetics
- ○ Other drugs or medications
- ○ Latex/ rubber products
- ○ Metals/ Jewelry
- ○ Other
- ○ None of the above

10. Have you now, or in the past, had any of the following; Please note the circle:

- ○ Heart trouble/ surgery
- ○ Rheumatic fever
- ○ Pacemaker
- ○ Stroke
- ○ Sinus problems
- ○ Leukemia
- ○ Hepatitis
- ○ Thyroid
- ○ Cancer or tumor
- ○ Aids
- ○ Syphilis
- ○ Stomach problems
- ○ Emotional problems
- ○ Chest pain
- ○ Irregular Heart
- ○ High blood pressure
- ○ Asthma
- ○ Anaemia/ Blood diseases
- ○ Abnormal prolonged bleeding
- ○ Diabetes
- ○ Kidney problems
- ○ Sudden weight loss and gain
- ○ Herpes
- ○ Arthritis
- ○ Eye problems
- ○ Epilepsy
- ○ None of the above

11. If you have any diseases, conditions, or problems not listed above, please explain which:

……

12. Do you take any medications? If yes, please fill out following:

NAME OF MEDICATION	AMOUNT TAKEN	REASON

I certify that to the best of my knowledge the above information is complete and accurate. If there are changes in my health, or medicines, I will inform my doctor at the next appointment.

I also understand that this information will be held in the strictest of confidence. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature of the patient/Guardian

………………………………………………………

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DENTAL HISTORY

What is the main problem you came here for? ……………………………………………………………………………………………

When was the last time you visited the dentist & for what reason? ………………………………

……

Does your gum bleed during teeth brushing? Yes ( ), no ( )

Who recommended us to you? ……………………………………………………………………

Did / do you experience:
Enter (✓) if yes

( ) Noises while opening or closing joint
( ) Do you grind your teeth during the day or night
( ) Pain inside or around ears and cheeks
( ) Splint for joint dysfunction therapy
( ) Wounds or areas with pain in your mouth
( ) Bad breath or bad taste
( ) Food impaction occurs in your teeth
( ) Orthodontic therapy

Do you like your smile?
Yes ( ) No ( )

Is there a treatment you would like to know more information about?
( ) Preventive dentistry (nutritional tips, prevention methods, brushing, etc.)
( ) Cosmetic dentistry (whitening, veneers, white filling, etc.)
( ) Restorative dentistry (periodontitis, gingivitis, root canal treatments laser etc.)
( ) Other, please specify...
( ) No

DATE..**SIGNATURE**...

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INFORMED CONSENT
General Consent for Treatment

The purpose of all of the following information is to inform you about any possibilities that can rarely occur and to inform you that we are prepared for each one of the following incidents.

All dental and anaesthetic procedures have associated risks. These may be, but are not limited to:

- Drug reactions and side effects
- Damage to adjacent teeth or fillings
- Post-operative infection
- Post-operative bleeding that might require additional treatment
- Delayed healing of an extraction site, (dry socket) necessitating additional care
- Sinus involvement during removal of upper molars which may require additional treatment of surgical repair at a later date
- Involvement of the nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas
- Bruising, swelling, sensitivity, or pain
- Failure of the dental instruments inside tooth canals making additional
- Breakage of dental instruments inside tooth canals making additional treatment necessary
- Complications during treatment necessitating referral to a specialist

I understand all the previous mentioned information.

Patient Signature..Date...................................

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PERSONAL DATA COLLECTION, PROCESSING BRIEFING & CONSENT FORM

(According to the EU Council's Regulation 2016/679 of the 27th of April 2016 for the protection of individuals as for the processing of personal data and the free circulation of this data and the abolition of 95/46 EK directive)

COLLECTION AND PROCESSING OF PERSONAL DATA

PURPOSE OF PROCESSING

Upon your arrival at the Centre for Holistic Dentistry Yiannikos, and prior to the beginning of your treatment, we collect the following:

Patient's full name, age, occupation, address and every other relevant information linked to your treatment, your general health and the purpose of your visit.

The preservation of this information is the legal obligation of the Centre of Holistic Dentistry Yiannikos, according to the ISO 9001:2008 Certification and it is maintained for 40 years.

The processing is necessary especially for identification and communication purposes, for monitoring your health's progress and for identifying your treatment needs.

DATA SUBJECT'S RIGHTS

You have the right to access, correct, delete, restrict and object to the processing and the mobility of your data, according to the articles 15- 22 of the General Data Protection Regulation (GDPR). In order to exercise your rights, you can contact us in writing to the address: 8 Alkaiou and Pindarou, P.C: 1060, Nicosia or in email to info@yiannikosdental.com.

PERSONAL DATA FORWARDING

Access to the archive is not open to any third parties, except when it is stipulated by the current regulations.

Additionally, we will be sending messages via the phone or via email to you relating to your condition or appointments. The Centre of Holistic Dentistry Yiannikos partners (dental technicians, other dental practices etc.) can process your personal data without any further notification.

The third parties whom your personal date are being forwarded to, do not have the right to use them for other purposes.

This information is strictly confidential.

Nicosia, date………………………………………………………

I am aware of the above and I give my consent.

The patient…………………………………………………………

INFORMED CONSENT
Photographs

I understand that photographs, x-rays, and other records may be made during the course of my examination, treatment, and follow-up care. I give my permission for such items to be used for purpose of research, education, or publication in professional journals.

☐ Yes

☐ No

How would like to be contacted?

☐ Telephone

☐ SMS

☐ E-mail

You would like to receive information and our newsletter regarding our clinic and methods?

☐ Yes

☐ No

This information is strictly confidential.

Nicosia, date………………………………………………….

I am aware of the above and I give my consent.

The patient…………………………………………………….

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