YIANNIKOS

Centre for Holistic Dentistry

PATIENT HISTORY

First Name : Last Name :

Date of Birth : Occupation:

Address/postal code :

Phone Number : Email :

Facebook/Instagram:

MEDICAL HISTORY :

Have you had any serious illness, operation, or been hospitalized within the last 5 years?

☐ **YES** ☐ **NO**

Do you smoke?

☐ **YES** ☐ **NO**

Women only

Are you pregnant or is there a possibility that you are? ☐ **YES** ☐ **NO**

Do you take birth control pills? ☐ **YES** ☐ **NO**

Are you allergic or have you had a reaction (swelling, rash, itching) to:

- ☐ Penicillin or other antibiotic
- ☐ Local anesthetics
- ☐ Other drugs or medications
- ☐ None of the above

Have you now, or in the past, had any of the following?

- ☐ Heart trouble/ surgery
- ☐ Stroke
- ☐ Leukemia
- ☐ Hepatitis
- ☐ Thyroid
- ☐ Cancer or tumor
- ☐ Syphilis / Aids
- ☐ Stomach problems
- ☐ Irregular Heart
- ☐ High blood pressure
- ☐ Anaemia/Blood diseases
- ☐ Abnormal prolonged bleeding
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Epilepsy
- ☐ None of the above

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

Do you take any medications?

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. ☐

DENTAL HISTORY :

What is the main problem you came here for?

Who recommended us?

Did/ do you experience

- [ ] Noises while opening or closing joint
- [ ] Grinding/Clenching of your teeth during the day/ night
- [ ] Pain inside or around ears and cheeks
- [ ] Splint for joint dysfunction therapy
- [ ] Wounds or areas with pain in your mouth
- [ ] Orthodontic therapy

Signature of the patient/Guardian

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 or 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 makes additional treatment necessary.
- Breakage of dental instruments inside tooth canals makes additional treatment necessary.
- Complications during treatment necessitating referral to a specialist

I understand all the previous mentioned information ☐

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 before the beginning of your treatment, we collect the following:

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

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

DATA SUBJECT'S RIGHTS

You have the right to access, correct, delete, restrict, and object to your data's processing and mobility, according to articles 15- 22 of the General Data Protection Regulation (GDPR). To exercise your rights, you can contact us by emailing info@yiannikosdental.com.

PERSONAL DATA FORWARDING

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

Additionally, we will send you messages via phone or email relating to your condition or appointments.

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Also, we will send you messages via phone or email about your condition or appointments.

The Centre of Holistic Dentistry Yiannikos partners (dental technicians, other dental practices, etc.) can process your data without further notification.

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

This information is strictly confidential.

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

INFORMED CONSENT

Photographs

I understand that photographs, x-rays, and other records may be made during my examination, treatment, and follow-up care. I allow such items for research, education, or publication in professional journals.

☐ **YES** ☐ **NO**

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

☐ **YES** ☐ **NO**

This information is strictly confidential.
Date

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

Signature of the patient/Guardian

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