zmk bern
Zahnmedizinische Kliniken
der Universität Bern

UNIVERSITÄT
BERN

Personal data and general state of health

Your information will be treated as strictly confidential and is subject to medical confidentiality.

Family name:

First name:

Date of birth (DD.MM.JJJJ):

Street/No:

Postcode/City:

Telephone P:

Telephone G:

Mobile:

E-Mail:

Sex: female male

Nationality:

Language:

Foreigner's identity card: B C N F

other:

Profession:

Health insurance company:

Family doctor (name, address, phone no.):

Dentist (name, address, phone no.):

Parent/guardian, legal representative, emergency contact person:

Family name:

First name:

Telephone:

Address:

Who will bear the costs:

- Self-payer
- Health insurance
- Supplementary benefits to AHV/IV
- Accident/disability/military insurance
- Social welfare/asylum
- Other:

What is the main reason for your visit to zmk bern?

How did you become aware of us?

Referring practitioner:

Other:

previous treatment at the zmk bern at (name/clinic/year):

Answering following questions truthfully is a prerequisite for your adequate and best possible consultation or treatment. If you are unsure, please ask your dentist or contact your family doctor.
Please inform us, promptly, of any changes in your state of health.

1. Have you recently undergone any medical treatment? yes no
   If yes, for what reason and with what doctor(s):
2. Do you take medication/drugs? (please list if applicable) yes no
   If yes, which drugs:
3. Do you have an anticoagulant card, allergy passport or other medical identification? yes no
   (Endocarditis prophylaxis, transplants, joint replacements, etc.)
   If yes, which one:
4. Do you have allergies? If so, which allergies: yes no
5. Have you ever been seriously ill and/or hospitalized? yes no
   Reason:
6. Do you wear a cardiac pacemaker? Year of insertion: yes no
7. Do you have artificial joints? Where: yes no
8. Do you have a hearing aid (removable or implanted)? yes no
9. Have you ever had an incident at the dentist? yes no
   (e.g. loss of consciousness or an unusual response to an injection)
10. Are you afraid of dental treatment? yes no
11. Have you ever had an accident, surgery or radiation in the dental/jaw/facial area? yes no
    If yes, please specify:
12. Do you suffer or have suffered from any of the following conditions:

Cardiovascular disorder	High blood pressure
Heart disease / heart attack	Respiratory / lung disease
Stroke / cerebral infarction	Liver / kidney disease
Glaucoma	Diabetes
Rheumatic disease	Thyroid disease
Epilepsy	Stomach/intestinal problem, frequent vomiting
Embolism / thrombosis	Tumor disease (cancer)
Osteoporosis	Chronic pain
Mental suffering (e.g. depression)	Comments:

13. Do you have or have you had any of the following infections:
    Tuberculosis Sexually transmitted diseases HIV/AIDS Jaundice/ Hepatitis A B C
14. Do you suffer or have you suffered from a disease that is not listed here? yes no
    If yes, which disease:
15. Do you smoke? If yes, how many cigarettes: yes no
    Since when? Stopped since:
16. Do you use smokeless tobacco products (e.g. snus or snuff)? yes no
    If yes, average amount per day:
17. Do you drink alcohol regularly? If yes, what and how much: yes no
18. Do you use other substances (e.g. drugs)? yes no
    If yes, what and how much:
19. For female patients: Are you currently pregnant? yes no
    If yes, in which month:
    Name and address of the gynecologist:

Declaration of consent, medical secrecy, data protection and applicable law:

I confirm that the information provided is complete and correct. I acknowledge that the place of jurisdiction is Bern and that Swiss law applies.

I give my consent that the treating staff at the zmk bern may request my data or medical information from other parties involved, discuss it in my interest and also forward it to authorized third parties (e.g. external laboratory order, referrals, obtaining cost approvals from insurance companies or offices).

I grant permission to forward the data required for the billing office both to the billing institution (e.g. medical insurance company) and to the institution commissioned with any debt collection or to the lawyer dealing with this as well as to the responsible state authorities. In this case, third parties only receive data that do not allow any conclusions to be drawn about the medical treatment.

Place, date: Signature:

(for minors legal representation)

Information about the use of health-related data and samples for research purposes

Dear Patient,

Our ability to diagnose and treat diseases has progressed significantly in recent decades. These advances are the result of long-standing medical research in which doctors, scientists and patients of several generations have actively participated. An important part of this research relies on patients' health-related data from medical history, such as results of laboratory analyses, therapy information or genetic predispositions. Any biological material collected during your stay that is no longer needed for the treatment is also extremely valuable for research. This residual material may be, for example, blood, saliva, tissue samples, X-ray images or models.

This leaflet explains how patients can contribute to medical progress and provides information in terms of data protection and associated rights. Thank you for your interest and attention.

How can you contribute to research?

By signing the declaration of consent with «Yes», you are making your clinical data and leftover samples available for research purposes. Data and samples include those that have been collected and will be collected during your hospital stay. Your consent is voluntary. It remains valid indefinitely or until withdrawn. You are entitled to withdraw your consent at any time without having to justify your decision. After withdrawal, your data and samples will not be available for new projects. Your decision has no effect on your medical treatment.

How are your health-related data and samples protected?

Data is stored within the hospital and protected in accordance with the applicable legal requirements. Only authorised employees from the hospital, e.g. physicians, have access to your uncoded data and samples. Your samples are stored in biobanks that contain structured collections of samples under safety regulations (biobank regulations).

If your data and samples are used for a research project, they will be coded or anonymised. Coded means that all personal information such as your name or date of birth is replaced by a code. The key showing which code belongs to which person is kept safe by a professional who is not involved in the research project. People who do not have the code are not able to identify you. In case of anonymisation, the link between the biological material and/or associated data and the participant is definitely removed so that no specific participant can be reidentified.

Who may use your health-related data and samples?

Data and samples may be used by authorised researchers for research projects within the hospital or in collaboration with public institutions (such as other hospitals) and private entities (such as pharmaceutical companies), in Switzerland and abroad. For research abroad, it must be ensured that at least the same data protection conditions are followed as in Switzerland. The projects may include genetic analyses for research purposes. Research projects relying on your data and samples have to be authorised by the relevant ethics committee.

Will you be informed about research results?

Research carried out with your samples and data will generally not reveal any individual information for your health. In rare cases, research results might be relevant or significant to your own health and clinical action might be possible. In these cases you might be informed.

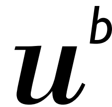
Will there be any costs or financial benefit?

There are no additional costs generated. The law excludes commercialisation of data and samples. Thus, no financial benefits will be generated for you or the hospital.

If you have any questions or would like additional information, please contact us at the address below or visit our website at

zmk bern
Freiburgstrasse 7, 3010 Bern, Phone +41 31 684 06 00
www.zmk.unibe.ch

Patient label



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Declaration of consent for the use of health-related data and samples for research purposes

Family name: First name:

Date of birth:

I herewith agree that my health-related data and samples collected during health care (ambulant or as an inpatient) will be made available for research purposes

Yes **No**

I understand
- the explanations about the further use of my health-related data and samples for research purposes that are detailed in the information sheet (January 2023).
- that my personal data are protected.
- that my data and samples may be used in national and international projects within the public and private sectors.
- that projects may include genetic analyses of my samples for research purposes.
- that I may be recontacted in case of individually significant findings, if any.
- that my decision is voluntary and has no effect on my treatment.
- that my decision is not limited in time.
- that I may withdraw my consent at any time without having to justify my decision.

Place, date Patient's signature, if judicious

Place, date Signature of legal representative, if required (Name and relationship to patient)

Please contact the following person or your physician if you have further questions or if you wish to receive a copy of this form with signature.

zmk bern, Freiburgstrasse 7, 3010 Bern, Phone +41 31 684 06 00, www.zmk.unibe.ch