Patient Questionnaire - Frauenpraxis Weinfelden (1/4)

FRAUENPRAXIS WEINFELDEN
im Hausarztzentrum

Personal data

First Name _____ Last Name _____

Date of Birth _____ E-mail Private _____

Phone Private _____ Mobile Private _____

Address _____

Occupation _____ Employer _____

Phone Business _____ E-mail Business _____

Emergency Contact (name/phone number) _____

Primary Physician/Other Specialists _____

Health Insurance (HI) _____ HI client number _____

DECLARATION OF CONSENT

for access to medical records, data sharing, release of confidentiality, and (image) data storage

I hereby authorize Frauenpraxis Weinfelden AG, Bankstrasse 2, 8570 Weinfelden, to obtain my medical records and all necessary patient data and to forward them in my interest to doctors and hospitals providing further and other treatment. To this extent, I release the previously treating medical personnel from the obligation of medical confidentiality. I confirm with my signature that I agree to the processing of my data, access to the data by the doctor, and the forwarding of the data to third parties in accordance with the patient information of the medical practice (display/webpage). The patient information is available in the practice and can be accessed on the webpage at any time. I am aware of potential risks associated with the exchange of particularly sensitive personal data (possible access by unauthorized third parties in the case of insecure communication channels) as well as my rights, and I give my consent for mutual contact between my doctor and myself as the patient through the contact information provided above. Patient information will only be shared by the medical practice through secure communication channels. I agree that administrative matters such as rescheduling appointments, may be communicated by unencrypted email (@hin address to recipient address such as @bluewin.ch, @gmail.com, etc.).

Please send the completed patient questionnaire via a secure connection by email (frauenpraxis-weinfelden@hin.ch) or bring the print-out with you to your first appointment.

Date / signature _____

(revocable at any time with effect for the future)

Specialists FMH in Gynecology and Obstetrics
Bankstrasse 2
8570 Weinfelden
Tel. 071 642 40 40
Fax 071 642 40 49
frauenpraxis-weinfelden@hin.ch
www.frauenpraxis-weinfelden.ch

Patient Questionnaire - Frauenpraxis Weinfelden (2/4)

FRAUENPRAXIS WEINFELDEN
im Hausarztzentrum

DECLARATION OF CONSENT

for billing and data forwarding within the scope of debt collection and invoice services

First Name _____ Last Name _____

Date of Birth _____

Address _____

We settle directly with your health insurance (tiers payant). As required by law, you will receive a copy of the medical bill. For this purpose, I give my doctor permission to obtain insured person data from the responsible offices. I give permission to forward the data required for billing to both Medidata as the billing entity and to the institution commissioned with any debt collection or attorney appointed for any debt collection, as well as to the relevant trust centers and state authorities. With my signature, I declare that the above information is true and accurate and that I have taken note of the fact that the doctor processes the billing electronically via Medidata. The consent given can be revoked at any time with effect for the future.

Please send the completed patient questionnaire via a secure connection by email (frauenpraxis-weinfelden@hin.ch) or bring the print-out with you to your first appointment.

Date / signature _____

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Patient Questionnaire - Frauenpraxis Weinfelden (3/4)

FRAUENPRAXIS WEINFELDEN
im Hausarztzentrum

Patient medical history

Age at first menstrual period: years

If menopause, what age did it occur: years

	Yes	No	Notes
Menstrual conditions?	☐	☐	
If yes, what:			
Pregnancy/birth?	☐	☐	
If yes, when:			
Natural / Cesarean?			
Miscarriages/other pregnancies?			
Past gynecological issues & surgeries?	☐	☐	
If yes, what?			
Did you have a mammogram in the past?	☐	☐	
If yes, when?			
Unfulfilled desire for children?	☐	☐	
Other past surgeries?	☐	☐	
If yes, what/when?			
Bladder conditions / problems with defecation?	☐	☐	
If yes, what?			
Do you use birth controls?	☐	☐	
Do you currently smoke/use alcohol/drugs?	☐	☐	
Allergies?	☐	☐	
Are you currently taking medication?	☐	☐	
If yes, what?			
Other conditions?	☐	☐	
High blood pressure/diabetes/thrombosis/embolism:			
Others:			

Family medical history

Breast/abdominal cancer in the family?	☐	☐	
If yes, what/affected relative and at what age?			
Thrombosis/pulmonary embolism?	☐	☐	
Diabetes?	☐	☐	
High blood pressure/heart conditions?	☐	☐	
Other?	☐	☐	
Genetic diseases?	☐	☐	

Various

Key point for first consultation?

Most important aspects in the doctor-patient relationship?

Print

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Patient Questionnaire - Frauenpraxis Weinfelden (4/4)

Patient information on the handling of personal data

In the following, we inform you about the purposes for which the medical practice mentioned above (hereinafter referred to as the "medical practice") collects, stores, or forwards your personal data. In addition, we inform you about your rights, which you can exercise within the framework of data protection.

Responsibilities The responsible body for processing your personal data, particularly your health data, is the medical practice. If you have any questions about data protection or if you wish to exercise your rights related to data protection, please contact the practice staff or your doctor directly.

Collection and purpose of data processing The processing (collection, storage, use, and retention) of your data is carried out on the basis of the treatment contract and legal requirements to fulfill the treatment purpose and associated obligations. Data is collected by the treating doctor as part of your treatment. Further, we also receive data from other doctors and healthcare professionals who have treated or are treating you, provided you have given your consent for this. In your medical history, only data related to your medical treatment is processed. The medical history includes personal information such as personal data, contact information, and insurance details provided on the patient form, as well as, among other things, the informative interview carried out as part of the treatment, health data collected, such as medical histories, diagnoses, therapy proposals, and findings.

Duration of retention Your medical history will be retained for 20 years after your last treatment. After that, with your express consent, it will be retained further or securely deleted and destroyed.

Disclosure of data We will only transmit your personal data, especially your medical data, to external third parties if it is permitted or required by law, or if you have consented to the transfer of data as part of your treatment.

- The data is transferred to your health insurance company or to the accident or disability insurance company for the purpose of billing for the services provided to you. The type of data transmitted is determined by legal requirements.
- Disclosure to cantonal and national authorities (e.g. cantonal medical service, health departments, etc.) is based on the legal obligations.
- Optional: The transfer of the necessary patient and billing data to the collection agency is for the purpose of collection (collection of overdue monetary claims).

In individual cases, depending on your treatment and corresponding consent, data is transferred to other authorized recipients (e.g. laboratories, other doctors).

Revocation of your consent If you have given your express consent for data processing, you may revoke it, in whole or in part, at any time. The revocation or request to change consent must be made in writing. Once we have received your written revocation, and if the processing cannot be justified on any other legal basis other than consent, the processing will be stopped. The legality of data processing carried out before the revocation remains unaffected by the revocation.

Information, access and disclosure You have the right to obtain information about your personal data at any time. You can access your medical history or request a copy. There may be a charge for providing a copy. Any costs dependent on the time and effort required to make the copy will be communicated to you in advance.

Right to data transfer You have the right to receive data that we process automatically or digitally in a commonly used machine-readable format, either for yourself or for a third party. This also applies, in particular, when transferring medical data to a healthcare professional of your choice. If you request the direct transfer of the data to another person responsible, this will only be done if it is technically feasible.

Correction of your data If you discover or believe that your data is incorrect or incomplete, you have the option to request a correction. If neither the correctness nor the completeness of your data can be established, you have the option of attaching a notice of dispute.

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