

Dear patient

Privatpraxen

We kindly ask you to complete this questionnaire carefully in order to provide you with a comprehensive service. Thank you very much.

Friedrichstraße 180 • 10117 Berlin
 Telefon: 030 / 886 226 - 0
 Telefax: 030 / 886 226 - 309
 E-Mail: info@citypraxen.de
www.citypraxen.de

Your practice team

Family name	First name	DOB
Address	Zip code, City	State
Phone	Mobile phone	
Profession / Occupation	E-Mail (will only be used for personal messages – no advertisement)	
Health insurance	Insurance number	

Please inform the following physician about diagnostic findings and medical treatment:

Physician	Address	Phone / e-mail
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If I am not available, please contact the following person in case of emergency:

Name, First name	Relation	Mobile phone
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Declaration of consent:

- My health insurance company has informed me about my medical cost, policy coverage and exclusions of benefits. I am aware that all consultations at CityPraxen^{BERLIN} are privately billed and that the medical remunerations are not covered by the tariff of German Doctor's Association (GOÄ). Therefore the charge rate can increase by three and a half times the amount of a regular consultation.
- I hereby agree, until revoked in writing, that my personal data and medical information will be stored at CityPraxen^{BERLIN} in compliance with the German legal requirements and will be available to all health professionals who may provide treatment at CityPraxen^{BERLIN}.
- Messages and diagnostic findings may be sent to me by e-mail.

Place, Date	Name (Please print)	Signature
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