RADIOTHERAPIE
STRAHLENTHERAPIE
Zentrum für Radio-Strahlentherapie
PRAXIS BERLIN

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Dear patient,

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

Your practice team

Family name	First name	DOB
Address	Zip code, City	State
Landline number	Mobile number	
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

If I am not available, please contact the following person in case of emergency:

Name, First name	Relation	Phone / E-mail

Declaration of consent

- Your health insurance has informed you of your health insurance plan restrictions and exclusions. I am aware that all consultations at Zentrum für Radio-Strahlentherapie are billed according to the tariff of German Doctor's Association (GOÄ). Therefore, the basic tariff rate can be increased by three and a half times and cannot be waived by unilateral announcements. Oral side agreements do not apply. In bilingual documents, in case of doubt, the German text is valid.
- You hereby agree, until revoked in writing, that your personal data and medical information will be stored in compliance with the German legal requirements and will be available to all health professionals who may provide the treatment.
- Messages and diagnostic findings may be sent to me by E-Mail.

Berlin,

Place, Date	**Name (in block capitals)**	**Signature**