CityPraxen BERLIN

Privatpraxen

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

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

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

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

Name, First name	Relation	Mobile phone

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**