GYNÄKOLOGISCHE PRAXISKLINIK
MÜNCHEN

PATIENT REGISTRATION

Last Name: ______________________________

First Name: ______________________ Date of Birth: ______________

Address: ______________________________

Phone Nr.: ______________________________

Email: ______________________________

Health Insurance: ______________________________

I hereby confirm that I can be contacted by phone after the surgery. ☐ yes

If you are a minor, please state the name and address of your legal guardian:

____

The lingering effects of a general anesthesia can last for 24 hours. Please confirm that an adult person will pick you up at the clinic after the surgery and stay with you for the first night.

Person picking up: ______________________ Mobile: ______________

Declaration of consent to the collection/transmission of patient data in accordance with §73 Para. 1b SGB

I consent that my referring doctor or other doctors (see below) receive a report of the surgery:

☐ yes ☐ no

Referring Physician/s: ______________________________

I consent that the employees of the gynecological practice clinic may view the data in my medical file:

☐ yes ☐ no

I agree that the physician treating me may collect the medical data required for my treatment from my referring physician/general practitioner or other healthcare providers and may process and use this data for the purpose of providing medical services. I can withdraw my consent at any time.

Date: ______________________ Signature: ______________________