

Registration form Basic information

(Please fill out in block letters)

1. Appointment confirmation

I hereby confirm the appointment

date:

time:

with:

Date: _____

Signature: _____

2. Personal details

Patient

Title:

Surname:

First name:

Date of birth:

Place of birth:

Birth name:

Height:

Weight:

Marital status: married unmarried

Husband / Partner

Title:

Surname:

First name:

Date of birth:

Place of birth:

Birth name:

Height:

Weight:

3. Address

Street:

Telephone (priv.):

Fax (priv.):

E-Mail (priv.):

(for encrypted communication)

Place:

Telephone (business):

mobile phone (priv.) patient:

mobile phone (priv.) partner:

4. Health insurance

Patient

statutory: _____
(name of health insurance)

private: _____
(name of health insurance)

subsidy: _____
(name of the benefits office)

Husband / Partner

statutory: _____
(name of health insurance)

private: _____
(name of health insurance)

subsidy: _____
(name of the benefits office)

5. How did you hear about us?

- Gynecologist Another doctor Friends FCH Homepage
- Media Instagram/Facebook were already in our treatment / another child
- Other: _____

**Patient statement for data transmission
to the gynecologist**

Surname/Firstname/Date of birth of patient

Please tick as appropriate

- I consent** to the transmission of the medical findings and doctor letters to my **Gynecologist** for now and in the future.

I am informed that I can revoke this consent in writing at any time.

Gynecologist:

Name: _____

Street: _____

Postal Code/Place: _____

Tel./Fax: _____

OR

- I don't** give any general permission to forward medical findings and doctor letters or advice to my gynecologist.

In case of important findings, I will, if appropriate, give my written consent for this particular case.

Date/Signature of female patient