

# PATIENT-REGISTRATION

title surname			
forename		date of birth	
SV-number (10-digits)		health insurance	
adress			
post code		city	
phone-number			
e-mail			
emergency contact (full name)		phone- number	
family doctor			
additional health insurance			
mass/weight		hight	
IBAN			

**To ensure an optimal low-risk treatment answer the following questions properly.  
Thank you!**

Do you suffer from allergies?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	If yes, which ones:	
Do you take certain anticoagulants?	<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>	If yes, which ones (z.B. Marcoumar, Plavix, Thrombo Ass)	
<b>Do you suffer from?</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
Hypertension (high bloodpressure)	<input type="checkbox"/>	<input type="checkbox"/>	gastric ulcera / gastritis	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	<input type="checkbox"/>	infectious diseases (Hepatitis, HIV)	<input type="checkbox"/>
neurological diseases	<input type="checkbox"/>	<input type="checkbox"/>	cancer	<input type="checkbox"/>
renal diseases (kidneys)	<input type="checkbox"/>	<input type="checkbox"/>	hypothyroidism	<input type="checkbox"/>
heart diseases	<input type="checkbox"/>	<input type="checkbox"/>	hyperthyroidism	<input type="checkbox"/>
angina pectoris / coronary heart diseases	<input type="checkbox"/>	<input type="checkbox"/>	psychological diseases	<input type="checkbox"/>

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	Yes	No	
Do you have a high bleeding tendency?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you take medications regularly? (long-term medication)	<input type="checkbox"/>	<input type="checkbox"/>	If yes, which ones:
Is there a risk of hereditary diseases?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, which ones:
Did you have operations in the past? (e.g. hip-/knee replacements)	<input type="checkbox"/>	<input type="checkbox"/>	If yes, which ones and when:
Do you have a pacemaker or artificial heart valves?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, which ones:

Where do you feel pain?
Since when are you in pain?
Have you had any therapies before? / Did you have any therapies before?
personal/individual comments

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## Declaration of consent:

I agree, that my attending physician is allowed to send any information memorized in my patient documentation to the previous mentioned e-mailadress in an unencrypted e-mail. This includes information about my health status at the beginning of treatment, history of diseases, diagnoses, progression of diseases, as well as nature and level of consultative, diagnostic or therapeutic interventions including the use of medicines and vaccines.

I take note of the risk that unauthorized (third) parties may gain access to sent data due to communicating personal data via unencrypted e-mail. This may also lead to a change of data.

I am aware that this may lead to publication of my personal state of health.

This declaration of consent can be cancelled at any time. The legitimacy about this declaration of consent is unaffected until the cancellation reaches our adress.

**If you don't agree to the declaration of consent please cross out the previous section.**

## patient education:

As in every medical treatment incl. orthopedical treatments, there can always be unforeseen complications. This means e.g. intolerances for drugs can lead to circulatory disorders. Due to the nature of invasive serving of drugs (e.g. intravenous infusions, infiltration of joints or muscles) there is always a low risk of infection although there are steril working conditions. If an infection occurs it might be necessary to take antibiotic medications or a surgical intervention. Haematomas are often side effects of infusions or infiltrations which are in most cases harmless.

**The risk of unexpected complications or side effects is very low (infections after intravasive serving of drugs ~1:10,000 patients). With your signature you agree to the treatment in our surgery and that you are fully aware of the possibility of complications.**

If you aren't able to make it to the assigned appointment, we ask you to tell us in time – this means at least 24hrs in advance. Otherwise we have to charge you for the appointment.

We would like to advise you to check your fee note immediately, because cancellation is not possible.

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Please notice, that certain treatments are not listed in the refund catalogue of your health insurance, this means that costs may not be covered by them.

I agree, that my IBAN is saved for the filing of invoices at my health insurance.

I don't want to receive a newsletter.

**Date:**

**Signature:**

Please tell us where you found us:

Herold	<input type="checkbox"/>	Google	<input type="checkbox"/>
Docfinder	<input type="checkbox"/>	Arztsuche 24	<input type="checkbox"/>
Praxisplan	<input type="checkbox"/>	Printmedien	<input type="checkbox"/>
Internet	<input type="checkbox"/>	Others	<input type="checkbox"/>