Confirmation of the use of medical treatment as a private patient

Bestätigung über die Inanspruchnahme ärztlicher Behandlung als Privatpatient

I hereby confirm that I have received medical treatment from
Ich bestätige die ärztliche Behandlung durch die

Neurologische Gemeinschaftspraxis
Drs. med. Mrass & Grünewald
Schifferstr. 13
60594 Frankfurt

as a private patient and furthermore that the following entries are correct.
als Privatpatient in Anspruch genommen zu haben und ferner die Richtigkeit der nachstehenden Eintragungen.

Please mark your payment method:

[ ] **I pay the medical fee directly at the registration desk of the medical practice.**
Ich entrichte das fällige Honorar direkt in der Praxis.

or

[ ] **I pay the medical fee directly via Ärztliche Verrechnungs Stelle Büdingen GmbH.**
(An official registration address in Germany is required for this option!).
Die Liquidation des Honorars erfolgt durch die Ärztliche VerrechnungsStelle Büdingen GmbH direkt an mich.

Frankfurt,

_____ _____
(Date / Datum) (Patient's signature / Unterschrift Patient/in)

PLEASE WRITE CLEARLY AND LEGIBLY

Name (Name)_____ First name (Vorname)_____

Date of birth (Geb.-Datum)_____Place of Birth(Geb.-Ort)_____

Residing in (wohnhaft in) :

Street (Straße)_____

Post code (Postleitzahl)_____City, Country _____

Mobile phone :_____ Local phone_____

E-Mail:_____

Occupation (Beruf) :_____

Family doctor (Hausärztin/-arzt):_____

Patient questionnaire

Dear patient,

Please show all your available medical reports to our employees.

→ hospital reports
→ medical reports
→ radiology reports (MRT, CT)
→ medication plan!

Without knowing your reports, helpful treatment is often not possible!

Last name: _____ First name: _____

Date of birth: _____Occupation: _____

Phone number: _____Mobil: _____

E-mail: _____ Weight: _____ Hight: _____

please check where applicable!

	yes	no	quantity per day/week
nicotine (cigarettes)			
alcohol			
	----	----	in your family
high blood pressure			
high cholesterol			
tumor disceases			
diabetes mellitus			
stroke/ apoplexy			
peripheral artery disease			
epilepsy			
asthma			
coagulation disorder			
infectious diseases (HIV? Hep.?)			
heart disease? (e.g.: cardiac arrhythmias, heart attack,…)			
mental illness? (e.g.: depressions)			
allergies (also on medication):			
surgery in the last years?			

please turn around →

please describe your current problems as precisely as possible.
(must be filled in!):

_____

_____

_____

_____

_____

_____

current medication (medication plan):

_____

_____

my family doctor is (with complete address):

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privacy

I agree, that my data can be exposed to all employees if necessary.

I have been advised that all employees are obliged to maintain discretion.

My data can ba submitted to third party affiliates e.g. local doctor, health insurance company via e-mail if required.

This permission can be withdrawn at any time.

I agree, that informations can be given to the following relatives, after their identity has been verified.

name: _____

name: _____

Frankfurt, ……..... .....
(Date) (Patient's signature)