PATIENTS' REGISTRATION FORM

_____
Last / First Name Date of Birth

_____
Street / House Number

_____
Postal Code / City

_____ _____
Phone (home) / Cell Phone eMail

_____ _____
Profession Health Insurance

_____ _____
Private Insurance How did you hear about us?

I need a medical report for my general practitioner no ( ) yes ( )

_____
General practitioner (Adress)

Additional general Indication

Do you suffer from an illness in the following areas?

Blood-, Cardiovascular, Sugar-, Thyroid no ( ) yes ( ) Which one: _____

Stomach, Intestine, Liver, Kidney, Lung no ( ) yes ( ) Which one: _____

Neurological- / psychologically no ( ) yes ( ) Which one: _____

Muskoloskeletal no ( ) yes ( ) Which one: _____

Infections Diseases no ( ) yes ( ) Which one: _____

Tumor Diseases no ( ) yes ( ) Which one: _____

Other Diseases no ( ) yes ( ) Which one: _____

Allergies: no ( ) yes ( )

Which one:
_____

Medication: no ( ) yes ( )

Which one:
_____

Operations: no ( ) yes ( )

Which one:
_____

Thank you!

_____ _____
Date Signature