TOPURO
UROLOGISCHE PRAXIS
AM STADELHOFEN

Dear Patient,

In order to provide you with medical care, we require some personal information from you. We kindly ask you to complete the form below. Thank you very much for your cooperation.

Personal Details

Last name

First name

Gender

☐ Male ☐ Female ☐ Other

Date of birth

Address (place of residence): Street

ZIP code, City

Mobile phone

Private phone

E-Mail

Business phone

Occupation

Employer / Company name

Health Insurance

Insurance company

Supplementary insurance

☐ General ☐ Semi-private ☐ Private

Insurance card number

General Practitioner

Name, First name

☐ I do not have a general practitioner

Address of general practitioner

You were referred by

Please also note the information on the reverse side.

Emergency Contacts

1st contact person
Name, First name

Address

Telephone

Relationship (partner, spouse, etc.)

2nd contact person
Name, First name

Address

Telephone

Notes

→ I authorize my physician to request access to my medical records and to forward medical findings to my treating or referring physician.

→ Applicable to all health insurance providers:
Costs for medications or materials that are not, or only partially, covered by health insurance will be invoiced directly to you and must be paid by yourself. This applies in particular to patients insured with Concordia and Atupri in the case of examinations requiring extensive use of materials.

By signing below, the patient confirms that the above information has been provided truthfully and that the above cost regulations have been acknowledged.

For minor patients, a parent or legal representative confirms the accuracy of the information and acknowledgement by signing below.

Date

Signature

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