Registration form

patient _____
family name first name date of birth

profession _____invoice recipient_____
(if not the patient) family name first name date of birth

address _____
street/ number postal code / city country

telephone number_____ cell phone number_____

e-mail _____

insurance _____ _____

additional hospitalisation insurance _____ 1 bed O 2-bed O head physician O

HIV pos. **O** yes **O** no history of hepatitis **O** yes **O** no

medical history/ allergies _____

_____

current medication _____

surgical history _____ _____

_____ _____
date signature patient or legal guardian

for your information:

For any adviced treatment, we always need your explicit consent.

Within our duty of disclosure, we want to point on the following facts

- Injections or punctures may very rarely cause little bleedings and/or injuries of the nerves
- In spite of correct methods, it is possible, but very rarely (ca 1 in 30 000), that you can get an infection of the joint or surrounding tissue.

If you‘re feeling violent pain after an injection or you increased fever, swellings or overheating at the treated area, please call us immediately or come into our medical practice.
In case of emergency please contact the nearest hospital/ emergency room.

Your signature is solely an acknowledgement of the information above, NOT an agreement to any treatment.

_____ _____
Date signature patient or legal guardian