Dr. med. Martin Böhringer

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Dr. med.
MARTIN BÖHRINGER
Facharzt für Orthopädie

Chirotherapie • Sportmedizin • Akupunktur
Naturheilverfahren • Stoßwellen • Osteologie
Digitale Röntgendiagnostik • Osteodensitometrie

Personal information

family name first name	child/relative	day of birth
city code city	street	no./app. no.
profession/workplace	family doctor	phone

important diseases/injuries	
major operations artificial joints or implants	
serious infections	hepatitis O type _____ tuberculosis O meningitis O MRSA O HIV O other
diabetes mellitus typeI/II	no O yes O insuline O oral drug O
pregnancy	no O yes O not shure O **We have to avoid X-ray!**
pacemaker	no O yes O
allergies/intolerances (of drugs or injections)	no O yes O which drugs/reactions:
asthma bronchial	no O yes O
gastric/intestinal ulcers or stomach bleeding	no O yes O no O yes O
antacids	no O yes O which?
duration drugs	no O yes O which?
antidepressants	no O yes O which?
cortisone	no O yes O ____ mg
anticoagulants	no O yes O ASA O Marcumar O Pradaxa O Eliquis O Xarelto O other _____
Attention: **No driving ability**	**You are not allowed to drive after injections!**

Consent to privacy policy, data processing and transmission

(§ 73 Abs.1 b SGB V and § 201 SGB VII)

Herewith I declare my approval for privacy policy, data storage and processing by the practice Dr. Böhringer. I could pay attention to the DSGVO privacy posting (at the wardrobe or on website).

I **agree** that treatment data and reports relating to me may be requested from other doctors, hospitals and service providers for the purpose of documentation, medical achievements and further treatments.

I agree that in case of requesting treatment data concerning me may be transmitted to doctors, the laboratory, hospitals, health/care insurance companies, professional associations or public authorities, e.g. industrial accidents and aid offices, employment agencies, other service or medical providers such as physiotherapists, orthopaedic technicians, masseurs or pharmacists.

I agree that I may be reminded of preventive or control examinations, vaccinations etc. and that medical reports, findings or treatment data may be sent to me or to the above-mentioned persons, if requested by the following **email address:** _____

I can revoke *this declaration in whole or in part for the future at any time. Please delete unwanted!*

Herzogenaurach _____ _____
date signature of the patient or legal representative