



## 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 <input type="checkbox"/> type _____	tuberculosis <input type="checkbox"/>	meningitis <input type="checkbox"/>
diabetes mellitus typel/II	MRSA <input type="checkbox"/>	HIV <input type="checkbox"/>	other <input type="checkbox"/>
pregnancy	no <input type="checkbox"/> yes <input type="checkbox"/>	insuline <input type="checkbox"/>	oral drug <input type="checkbox"/>
pacemaker	no <input type="checkbox"/> yes <input type="checkbox"/>	not shure <input type="checkbox"/> <b>We have to avoid X-ray!</b>	
allergies/intolerances (of drugs or injections)	no <input type="checkbox"/> yes <input type="checkbox"/>	which drugs/reactions:	
asthma bronchial	no <input type="checkbox"/> yes <input type="checkbox"/>		
gastric/intestinal ulcers or stomach bleeding	no <input type="checkbox"/> yes <input type="checkbox"/>		
antacids	no <input type="checkbox"/> yes <input type="checkbox"/>	which?	
duration drugs	no <input type="checkbox"/> yes <input type="checkbox"/>	which?	
antidepressants	no <input type="checkbox"/> yes <input type="checkbox"/>	which?	
cortisone	no <input type="checkbox"/> yes <input type="checkbox"/>	_____ mg	
anticoagulants	no <input type="checkbox"/> yes <input type="checkbox"/>	ASA <input type="checkbox"/>	Marcumar <input type="checkbox"/> Pradaxa <input type="checkbox"/>
		Eliquis <input type="checkbox"/>	Xarelto <input type="checkbox"/> other _____
<b>Attention: No driving ability</b>	<b>If you have received or are taking an injection, painkiller, narcotic or sedative, you are unfit to drive!</b>		

## 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