DERMATOLOGIE AESCHE 48

Patient-Questionnaire

Surname First name

(for minors: surname and firstname of parent or person with legal parental authority)

Date of birth Nationality

Gender ☐ male ☐ female

Street/No. ZIP/City

Tel private Tel mobile

E-Mail

Profession Tel work

Employer (Name/Adress)

Are you receiving: ☐ AHV ☐ IV ☐ Social welfare

If so please specify contact person/adress:

Health insurance AHV-No. 756.

Accident insurance Health insurance deductible

Referring doctor Family doctor

Do you suffer from any allergies/incompatibilities ? ☐ None

If so please specify:

Do you suffer from diabetes? ☐ Yes ☐ No

Do you suffer from cardiovascular diseases? ☐ Yes ☐ No

Do you suffer from any infectious disease (HIV, hepatitis etc.)? ☐ Yes ☐ No

Which medications do you take regularly? ☐ None

Women: Are you pregnant? ☐ Yes ☐ No

If so: in which week of pregnancy?

With the signature below I give the permission that relevant data about me can be sent to the invoicing party, a collection agency or lawyer as well as to the responsible state institution.

My doctor is entitled to request medical files which could be related to my illness.

If you are unable to keep your appointment please notify us 24hrs in advance. If you fail to appear, we will charge CHF 100.- or in the case of cosmetic treatments half of the costs of the treatment.

Place/Date Signature

(in case of minors: signature of parent or person with legal parental authority)