Specialists in Neurology

Christina Käding
Dr. med. Raphael Friedl
Bernd Hellmann
Fachärzte für Neurologie

Name:	**Date of birth:**
Telephone:	E-mail:
Job:	

How did you find us?			
By Internet		Recommendation by another Doctor	
Well-known		Other	
other: (please name)			

Do you have any of the following diseases?	
Diabetes mellitus	High blood pressure
Thyroid disease	Angina pectoris
Liver disease	Other heart problems
Kidney disease	Circulation disorder
Elevated blood lipid levels	Varicose veins
Elevated uric acid values(gout)	Cancer
Other diseases:	
Medication on a regular basis?	**If yes, please name:**
☐ yes ☐ no	
Do you have a drug intolerance?	**If yes, please name:**
☐ yes ☐ no	
Do you suffer from allergies?	**If yes, please name:**
☐ Yes ☐ no	
Which operations have already been done?	
Current complaints? / reason for your coming?	

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Declaration of consent for the transmission/collection of patient data

§ 73 Abs. 1 b SGB V

I _____
(First name, last name, place of residence, date of birth)

declare that

- My doctor communicates my treatment data and findings to the referring doctor for the purpose of the documentation to be provided to the referring physician and further treatment.
- the treating physician collects from my referring physician or other physicians or service providers the treatment data and findings required for my treatment and processes and uses them for the purposes of the medical services to be provided by my attending physician.

Report of findings please to: _____

_____

_____

I understand that I may revoke this statement at any time in whole or in part for the future.

_____ _____

(Place and date) (Signature of patient or legal representative)

Note: For other than the above Purposes my doctor may not transmit, process and use my treatment data and findings.