DERMATOLOGIE
PROF. HERCOGOVÉ

INFORMED CONSENT WITH THE HEALTHCARE

THE PATIENT

Name and surname, titles: ………………………………………………………………………………………………

Birth number (foreigners insurance number): ……………………………………………………………………

Residence (including postal code): ………………………………………………………………………………….

Name and code of the insurance company: ……………………………………………………………………

Telephone number: …………………………………………… E-mail address: …………………………………..

Name and address of the G.P.: ……………………………………………………………………………………..

THE LEGITIMATE REPRESENTATIVE

Name and surname, titles: ………………………………………………………………………………………………

Relation to the patient: …………………………………………………………………………………………………

Birth number or date of birth: ………………………………………………………………………………………

Telephone number: ………………………………………………………………………………………………………

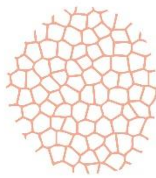
Residence (including postcode): ……………………………………………………………………………………

- I have been informed about our workplace's paid services. I undertake to respect the pricing policy stated in the price list of the medical department which is available on request at the reception of the department.
- Consent to provide information: I agree that information about my health condition may be provided to the following person(s) who may also inspect my medical records and make listings, transcripts or copies:
    - Name and surname:Klikněte nebo klepněte sem a zadejte text.
    - Residence:Klikněte nebo klepněte sem a zadejte text.
    - Telephone/e-mail:Klikněte nebo klepněte sem a zadejte text.
    - Information in the form of (mark): SMS / E-mail / Telephone / Written form / In person
    - In case of nno-personal contact, I set a **PASSWORD**: ……………………………………………

I have learned about you:

☐ the web page ☐ doctor's recommendation

☐ patient's recommendation ☐ social networks



HEALTH INFORMATION

The provided information is confidential. It helps the doctor to diagnose and treat your disease.

1. DISEASES IN MY FAMILY:

Tumors:……………………………………………………………… Allergies, asthma, hay fever:……………………

Skin diseases:…………………………………………………… Other:…………………………………………………….

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2. MY DISEASES (I HAVE / HAD THE FOLLOWING DISEASES):

☐High blood pressure	☐Diabetes	☐High fat levels	☐Stroke
☐Heart attack	☐Kidney disease	☐Hepatitis	☐Migraine
☐Intestinal inflammation	☐Gastric ulcer	☐Arthritis	☐Thyroid gland
☐Tumor	☐Higher bleeding	☐Leukemia	☐HIV
☐Tuberculosis	☐Asthma	☐Bronchitis	☐Depression

Other diseases: ………

Surgery /year: ……

Injuries /year: ………

I regularly take those drugs: ………………………………………………………………………………………………

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Allergies (drugs, food, other): ……………………………………………………………………………………………

Do you smoke? ☐Yes/☐No **Do you drink alcohol?** ☐Yes/☐No **Do you exercise regularly?** ☐Yes/☐No **Weight (kg):**………………………………. **Height (cm):** ……………….

I go for a preventive skin examinations: ☐Yes/☐No **I have a tattoo**: ☐Yes/☐No
I have a congenital skin defect (pigment spot, hemangioma, stork bite spot..): ☐Yes/☐No
I visit solarium: ☐Yes/☐No **Do you protect yourself from UV radiation?** ☐Yes/☐No

Incapacity for work/ Invalid pension for current skin diseases: ☐Yes /☐No Since when? …………………………

Prague, date: ……………………….
Patient's (Legitimate representative's) signature: …………………………………………………………….

NOTICE: We would like to inform you, there is the annual administrative fee 800 CZK which is not a condition for providing healthcare.