DERMATOLOGIE
PROF. HERCOGOVÉ

ENTRY FORM

Patient´s full name: _____ **Health insurance company**: _____

Date of birth: _____ **Personal ID number**: _____ **Nationality**: _____

Gender*: ☐ female ☐ male **Driving license**: ☐ YES ☐ NO **Firearms license**: ☐ YES ☐ NO

*gender assigned at birth

Email: _____ **Phone** (*incl. country code*): _____

Permanent residence / registered residence address in the Czech Republic:

Street, Number: _____ City: _____ Postal Code: _____

Contact address, if different from the permanent residence address:

Street, Number: _____ City: _____ Postal Code: _____

Password for communication: ☐☐☐☐ *Please choose a four-digit numeric code to verify your identity during phone consultations and to open password-protected messages.*

If you forget your password, you will be asked a security question: your mother's maiden name / the name of your first pet / the name of your best friend. Please choose any version and fill in the answer: _____

Declaration:

☐ I confirm that **I have read the Price List and the General Terms and Conditions for the Provision of Care**, which are available at the reception and on the clinic's website, that I understand them and accept them without reservation.

☐ I acknowledge that the clinic, as a healthcare provider, **processes personal data** of patients, their representatives, or persons close to them (including health-related data) as a data controller in connection with the provision of healthcare services. **I consent to the processing of the personal data** that I provide to the clinic. **I confirm that I have read the information on personal data processing**, which is available at the reception and on the clinic's website.

☐ **I consent to the sending of medical reports, results, invoices and payment documents, and other documents to the above-mentioned email address**, which the clinic may consider as verified, and I am aware of the risks associated with unsecured electronic communication (the possibility of access by unauthorized persons, loss, destruction, unauthorized disclosure).

☐ **I consent to receiving information** about news, offered healthcare services, and satisfaction surveys concerning the services of the clinic and other healthcare facilities within the Multi-klinika to my above-mentioned email address. Detailed information on personal data processing, including a list of healthcare facilities within the Multi-klinika, is available at the reception.

Please inform us of any changes in the data you have provided to the clinic. A form for granting consent to provide information to persons without the communication password or for giving explicit refusal is available at the reception upon request.

Please notify us of any appointment cancellation at least 24 hours in advance. Kindly note that if you fail to attend an appointment without notice or cancel it less than 24 hours in advance, the clinic is entitled to claim compensation for damages in the flat amount of CZK 1,000.

The annual administrative fee is CZK 800; its payment is not a condition for the provision of healthcare.

Date: _____ Signature: _____

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MEDICAL QUESTIONNAIRE

Dear Sir/Madam,
In connection with the planned provision of healthcare at our clinic, we kindly ask you to complete this questionnaire carefully and truthfully. Any illness may affect your treatment. All the information provided will become part of your medical records, which are subject to the legal duty of confidentiality of healthcare professionals and are therefore completely secure. The information will be used solely to adapt the treatment to your state of health. Please mark the appropriate answer with a cross.
Thank you.

1. Family Medical History

☐ Tumors (oncological diseases): _____

☐ Allergies: _____ ☐ Skin diseases: _____

☐ Other serious illnesses: _____

2. Medical History

Are you currently being treated for, or have you ever had, any of the following conditions? (please tick)

☐ High blood pressure ☐ Diabetes ☐ High cholesterol ☐ Stroke ☐ Heart attack

☐ Kidney disease ☐ Hepatitis ☐ Tuberculosis ☐ Stomach ulcer ☐ Arthritis

☐ Thyroid disease ☐ Tumor ☐ Asthma ☐ Leukemia ☐ Intestinal inflammation

☐ Bronchitis ☐ HIV ☐ Migraine ☐ Depression ☐ Increased bleeding tendency

☐ Other illnesses: _____

☐ Surgeries (type+when): _____

☐ Injuries (type+when): _____

☐ Medications taken regularly: _____

_____

Allergies:

☐ Medications ☐ Foods ☐ Other

_____

3. Lifestyle and Habits

Do you smoke? ☐ regularly ☐ occasionally ☐ not at all

Do you drink alcohol? ☐ regularly ☐ occasionally ☐ not at all

Do you use narcotics? ☐ regularly ☐ occasionally ☐ not at all

Do you exercise? ☐ regularly ☐ occasionally ☐ not at all **Do you have tattoos?** ☐ yes ☐ no

Do you protect yourself from UV radiation? ☐ yes ☐ no **Do you use a tanning bed?** ☐ yes ☐ no

Height (cm): _____ **Weight (kg):** _____

Do you have a congenital skin condition (birthmark, hemangioma, port-wine stain)? ☐ yes ☐ no

Sick leave/disability pension due to current skin disease: ☐ no ☐ yes – since when: _____

Date: _____ Patient´s signature: _____ Doctor´s signature: _____