

Initial consultation

Please email us this form completely and legibly, together with the anamnesis forms for women and men and any copies of your findings.

For the transmission of health data, we have included a SecureFile link for data security reasons.

Thank you very much!

FEMALE PARTNER

Title _____

First name _____

Last name _____

Date of birth _____

Place of birth _____

Nationality _____

Occupation _____

Marital status _____

Telephone _____

E-mail _____

Street adress _____

Zip code Town _____

State _____

Insurance

I am covered by compulsory social insurance in Austria

Health insurance fund _____

Insurance number (e-card) _____

MALE PARTNER

Title _____

First name _____

Last name _____

Date of birth _____

Place of birth _____

Nationality _____

Occupation _____

Marital status _____

Telephone _____

E-mail _____

Street adress _____

Zip code Town _____

State _____

Insurance

I am covered by compulsory social insurance in Austria

Health insurance fund _____

Insurance number (e-card) _____

PLEASE TURN!

Female partner / Insurance / continued:

- I have private special class (Sonderklasse) supplementary insurance.

Health insurance company _____

Policy number _____

- I will pay for the services directly (no private special class supplementary insurance).

Male partner / Insurance / continued:

- I have private special class (Sonderklasse) supplementary insurance.

Health insurance company _____

Policy number _____

- I will pay for the services directly (no private special class supplementary insurance).

Referring Physicians

Primary care physician _____

Gynaecologist _____

Urologist _____

Is there anything else you would like to tell us about?

Statement of consent with regard to the use of data:

- I authorize the Confraternität & Goldenes Kreuz Private Hospital to use the information I have provided above – [data protection statement](#) – for the purposes of completing my registration for an initial consultation. I may revoke this authorization at any time by sending an email to datenschutz@mavie-med.at.

Location, Date _____

Signature female partner _____

Signature male partner _____