dr. helmuth obermoser
Arzt für Allgemeinmedizin

Registration form

Surname _____ **First name** _____

Date of Birth _____ **Tel.Nr.** _____

Home Adress:

Place of Residence _____ **Post Code** _____

Street _____

Accomodation/Hotel _____ **Departure** _____

With minors:

Name of the insured _____

Date of Birth of the insured _____

General questions

- **Could you be pregnant?**
- **Do you suffer from a form of allergy? If yes, which?**

With your signature you confirm that the information above is correct. Furthermore you accept that your treatment is regarded as privat medical care, that has to be paid in house and that the costs possibly are not covered by the statutory health insurance. However, ordinerily, they are covered by your foreign health or accidentinsurance. The hendling of this reimbursement is the patient's responsibility.

Date: _____

Signature _____