# REGISTRATION FORM BAARER KINDERARZTPRAXIS
# and
# Declaration of Consent for the Handling of Personal Data

**Personal details CHILD** (Please complete in block capitals)

| | |
|---|---|
| First name: | Last name: |
| Sex: m ☐ / f ☐ / d ☐ | Date of birth: |
| Address: | Postcode / town: |
| Health insurance company | |
| Former family doctor | |

**Personal details parents**

| **Contact 1** | **Contact 2** |
|---|---|
| First name: | First name: |
| Last name: | Last name: |
| Address: | Address: |
| Postcode / Town: | Postcode / Town |
| Tel./Mobile 1: | Tel./Mobile 2: |
| E-Mail 1: | E-Mail 2: |

**Legal representative if necessary**

| | |
|---|---|
| Institution: | |
| First name: | Last name: |
| Address: | Postcode/ town |
| Tel./Mobile: | E-Mail: |

By signing, I confirm that I consent to my data being processed, to my data being accessed by the doctor, and to my data being disclosed to third parties in accordance with the patient information on the next page.

I am aware of the potential risks of sharing particularly sensitive personal data (possible access by unauthorised third parties through non-secure communication channels) and of my rights, and consent to mutual contact between my doctor and myself as patient using the indicated contact details. Patient information will only be disclosed by the medical practice via secure communication channels. I hereby note that administrative matters, such as the postponement of appointments, are handled using unencrypted email (to recipient addresses such as @bluewin.ch, @gmail.com.)

Under the Health Insurance Act, patients receive a copy of the medical bill.

| | |
|---|---|
| Place, date | Signature |

**Appointments that are not cancelled with at least 24 hours' notice may be charged. Please let us know in good time.**