SPORT MEDICA S.A.
NZOZ CAROLINA MEDICAL CENTER
ul. Pory 78, 02-757 Warszawa
Nr ks. rejestrowej 000000024799
tel. (22) 355 82 00, fax (22) 355 82 10
cmc@carolina.pl, www.carolina.pl
REGON 016291775

CR.0001.0002.EN.V20151021

Patient registration form

Patient ID

1 Personal data

First name | Surname

Sex ☐ Female ☐ Male | Date of birth __ – __ – ____ | PESEL

Type of the identity document ☐ ID card ☐ Passport ☐ Other *(give name)*

Series / number of the document | Citizenship

Provincial branch of the NFZ *(if applicable)*

2 Contact details

Address of residence

Street | House No | Flat No

Zip code | City / town | Country

Mailing address (if different from above)

Street | House No | Flat No

Zip code | City / town | Country

Contact details

Cell phone No | Home phone No

E-mail address

3 Sports

Discipline's name ☐ Amateurishly ☐ High- performance ☐ Professionally

Discipline's name ☐ Amateurishly ☐ High- performance ☐ Professionally

4 Payer *(ie. Insurance company if applicable)*

Payer's name | Payer's tax No

Street | House No | Flat No

Zip code | City | Country

Pursuant to Article 24 of the Personal Data Protection Law of 29 August 1997 (Journal of Laws of 2014, item 1182, as amended), Sport Medica S.A. with its registered office in Warsaw at ul. Pory 78 (02-757 Warszawa), being the data administrator, hereby informs you that the personal data - to the extent provided in the patient registration card - are collected in order to provide medical services.

__ – __ – ____
Date

You have the right to access the contents of these data and update them. The data are provided voluntarily, but they are necessary to provide a service in a proper way.

☐ * I give my consent for Sport Medica S.A.to send me, by electronic means of communication (e-mail) and/or telephone, including short text messages) information on the planned appointments with doctors, medical examinations and procedures.

Signature of the person who submits the declaration (legible)

☐ * I agree to have my personal data included in this form, i.e. only the name, surname, date of birth, telephone and e-mail address, processed for marketing purposes, as well as offering and selling services and products by:

☐ * Sport Medica S.A. with its registered office in Warsaw, ul. Pory 78.

☐ * LUX MED sp. z o.o. with its registered office in Warsaw ul. Postępu 21C.

__ – __ – ____
Date

☐ * I give my consent for Sport Medica S.A. and/or LUX MED. sp .z o.o. to send me commercial information by electronic means pursuant to the Act on Rendering Electronic Services of 18 July 2002 (Journal of Laws of 2002, No. 144, item 1204, as amended).

I declare that pursuant to the Personal Data Protection Act (Journal of Laws of 2014, item 1182, as amended) I have been informed that provision of the data for marketing purposes is voluntary, that I have the right to access the contents of these data and update them, about the right to request in writing for discontinuation of their use for marketing purposes, as well as the objection, to which I am entitled with respect to each of the above-mentioned entities.

Signature of the person who submits the declaration (legible)

(*) please put X mark in the case you give the consent

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Patient's statement of authorization / denial of authorization to obtain information / medical records

☐ **Patient*** ☐ **Legal guardian/representative***

I, the undersigned Name Surname

Holder of ☐ ID card* ☐ Passport* Series Number

PESEL (Polish Resident Identification Number) Date of birth – –

Name and surname of child**

Child PESEL (Polish Resident Identification Number)** Child date of birth** – –

I state that to obtain information on my / my child's* state of health and health services:

☐ **Do NOT authorize anyone*** ☐ **Hereby authorize Mr / Ms***

Name Surname

Holder of ☐ ID card* ☐ Passport* Series Number

PESEL (Polish Resident Identification Number) Date of birth – –

Providing the person's contact detail's:

Street Building no Flat no

Postal code City Country

Phone number

I state that to obtain my / my child's* medical records (including medical results)

☐ **Do NOT authorize anyone*** ☐ **Hereby authorize Mr / Ms***

Name Surname

Holder of ☐ ID card* ☐ Passport* Series Number

PESEL (Polish Resident Identification Number) Date of birth – –

Providing the person's contact detail's:

Street Building no Flat no

Postal code City Country

Phone number

I hereby declare, I have been informed that any information about my/my child's state of health, provided health services and medical records are available only for patient, legal guardian/representative, authorized person and public authorities (e.g. court). Without authorization we would not make any of the above mentioned details available.

– – Date

– – Date

Signature of the person completing the statement (legible)

Signature of the person receiving the statement (legible)

In case of patients aged between 16 and 18 years old the statement must be signed by patient and legal guardian/representative

(*) Mark the correct one.

(**) Fill if applicable.