CAROLINA
medical center
GRUPA LUXMED

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.V20170130

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 Payer *(i.e. Insurance company if applicable)*

Payer's name | Payer's tax No

Street | House No | Flat No

Zip code | City | Country

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yes ☐ no ☐ I agree to receive marketing communications from Sport Medica S.A. and other companies of the LUX MED Group intended to promote the services offered by these companies, to inform about events related to their activities and to promote a healthy lifestyle, using my personal data:

yes ☐ no ☐ e-mail address (to receive e-mail messages)

yes ☐ no ☐ telephone number (to receive text messages: SMS, MMS, and incoming phone calls)

yes ☐ no ☐ I hereby give my consent to Sport Medica S.A. and other LUX MED Group companies to process for marketing purposes, including profiling, my personal data obtained from ordering processes or by using the services of these companies, or which I myself disclosed on their contact forms. This consent applies in particular to all my personal details, which include information about the way I use the services of the above-mentioned companies.

__ – __ – ____
Date

Signature of the person who submits the declaration (legible)

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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.