MiraMed®

Aesthetic Plastic Surgery
Oral and Maxillofacial Surgery

Registration Form

Welcome to the MiraMed Clinic. Please fill in these pages conscientiously and always use block letters.
All particulars are subject to patient / physician confidentiality.

Surname:	
First Name:	
Date of Birth:	
Address:	
Telephone:	
Fax:	
E-mail address:	
Consultation Appt: (at least 1 day before OP)	
Date of Operation:	
Operation planned: (your request)	
Other treatments required:	
Certification of surgical suitability:	from ☐ family doctor ☐ MiraMed
Accommodation:	☐ Self-booking Name of B&B / Hotel:
Arrival by:	☐ Car ☐ Train ☐ Plane

I have read, understood and accepted the General Business Conditions (GBCs).

IMPORTANT: The date of consultation and operation has to have been previously agreed upon in writing or in a telephone conversation in conjunction with the registration office at MiraMed prior to the filling out and sending of this form.
In case of the cancellation of hotel reservations, the cancellation conditions of the hotel in question are to be taken into account. MiraMed assumes no liability in this case.

__________________________ ______________________________

Place, Date Signature of Patient

My signature confirms that I agree to the General Business Conditions (GBCs) and that I have answered all the questions regarding my state of health **(please also fill in the back)** to the best of my knowledge.

Questions on my State of Health

Height: Weight:

Have you been in hospital or had medical treatment over the past years? ☐ Yes ☐ No

If yes, for which illnesses?

Are you taking any medication at present? ☐ Yes ☐ No

If yes, please enter all tablets, capsules, medicines and homeopathic medicines you are taking:

Have you ever had any adverse side-effects to injections, infusions or medications? ☐ Yes ☐ No
If so, in what way?

When and why did you have any previous operations?

Were you able to tolerate the anaesthetic? ☐ Yes ☐ No

Have any blood relatives been involved in incidents with anaesthetic? ☐ Yes ☐ No

Do you or did you suffer from the following illnesses: ☐ Yes ☐ No

⇒ Coronary heart disease: ☐ Yes ☐ No

⇒ Thyroid illnesses: ☐ Yes ☐ No

⇒ Circulation problems (i.e. too high or too low blood pressure, thromboses etc): ☐ Yes ☐ No

⇒ Acute or chronic infectious diseases (i.e. Hepatitis or HIV): ☐ Yes ☐ No

⇒ Respiratory diseases (TBC, asthma, bronchitis, etc.): ☐ Yes ☐ No

⇒ Muscular diseases, related to yourself or blood relatives: ☐ Yes ☐ No

⇒ Liver diseases (jaundice, fatty liver, etc.): ☐ Yes ☐ No

⇒ Diabetes: ☐ Yes ☐ No

⇒ Nerve and mental disorders (epilepsy, paralysis, depression, etc.): ☐ Yes ☐ No

⇒ Blood diseases or clotting disorders (increased bruising, nose bleeds, longer bleeding, etc.), related to yourself or blood relatives: ☐ Yes ☐ No

⇒ Varicose veins or other vascular diseases: ☐ Yes ☐ No

⇒ Rheumatism, rheumatic fever: ☐ Yes ☐ No

⇒ Allergies: ☐ Yes ☐ No

⇒ Other serious illnesses: ☐ Yes ☐ No

⇒ Feeling of numbness in the face or other parts of the body: ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Do you smoke? If yes, how much do you smoke a day?

Are your teeth loose? ☐ Yes ☐ No

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