Inquiry form for patients

Please fill out the following form completely. Your information helps us to be able to work on your desires and your future stay in Germany.
You can fill out the form on-line at the computer or download the form and send it by email at info@medical-crossborder.com or by fax at +49 231 55 63 73.

Patient Information	
Last name *	
First name *	
Address	
Country *	
Email *	
Phone	
Fax	
Birth date	
Nationality	
Gender	M ☐ F ☐
Medical Information	
What medical service spectrum are you interested in?	
Intestinal Disorders ☐ Prostate and Bladder Disorders ☐ Hip and Knee Arthroplasty ☐ Oncology ☐ Cardiology ☐ Oral and Maxillofacial Surgery (OMS) ☐ Health check-up ☐	Breast Surgery ☐ Vascular Surgery ☐ Paediatrics ☐ Neurosurgery ☐ Anthroposophical Medicine ☐ Other services ☐ _____
Medical Information	

Protection of privacy:
Medical crossborder is very interested in the privacy and safety of our visitors. The indication of your personal data is strictly voluntary, however we need, in order to be able to answer you, at least your E-Mail address and your name. These fields are marked (*) as mandatory fields. All information registered and your personal data is strictly treated confidentially. We do not provide any information supplied to any outside organization for any reason.

Your diagnosis / medical problem	
Desired medical treatment	

Do you have medical documentation and medical reports? Which one can you send to us?	
Physician´s letter ☐	Hospital discharge letter ☐
Surgery report ☐	Report course of disease ☐
Diagnostic and radiologic Informationen	
Laboratory test ☐	X-ray ☐
Cardiogram ☐	CT / MRI Pictures ☐

Referring Physician **Please provide us with the name and contact information of your physician:**	
Name	
Phone	
Fax	
Email	

If you are interested in a Health Check-up, what kind of Health Check-up do you wish?	
Full Health check-up ☐	Health check-up for high-risk groups: Cardiovascular health check-up ☐ Smoker health check-up ☐
Service Information	

What languages do you speak?	
English ☐	German ☐
Chinese ☐	other:_____
Optional services **What optional services do you require?**	
Stay in hospital: 1-Bed-Room ☐ 2 Bed-Room ☐	Treatment by Chief Physician ☐
How many persons do accompany you?	
Number accompanying persons: _____	therefrom children:_____
Do your accompanying persons need accomodation? Yes ☐ no ☐	
Is this your first treatment in one of our hospitals?	
Yes ☐ no ☐	
If no, in which hospitals have you been treated:	
How did you find out about Medical crossborder?	
Embassy ☐	Internet ☐
Referring Physician ☐	Relatives / friends ☐
Employer ☐	Insurance company ☐
other:_____	
Do you have further requests, which are not included in the inquiry form, **or you would like to add any other information, please type it here:**	

Due to these data we can work on your inquiry more specific. You will receive shortly a detailed answer from us.