

PATIENT REGISTRATION FORM FOR MINORS

PATIENT DATA

Name _____ Surname _____

Sex ☐ F ☐ M Date of birth -- PESEL

Address of residence in Poland ☐ No address of residence in Poland

Street _____ Building number _____ Flat number _____

Postal code _____ Town / City _____

DATA OF THE LEGAL GUARDIAN REGISTERING THE PATIENT

Name _____ Surname _____

Sex ☐ F ☐ M Date of birth -- PESEL

If you have no Polish personal identification number PESEL:
 Passport series and number _____ Nationality (Country) _____

Phone number (+48) _____

Email address _____

Address of residence in Poland ☐ None ☐ Same address of residence as the patient's ☐ Other address of residence than the patient's:

Street _____ Building number _____ Flat number _____

Postal code _____ Town / City _____

DATA OF THE SECOND LEGAL GUARDIAN

☐ NONE

Name _____ Surname _____

Sex ☐ F ☐ M Date of birth -- PESEL

If you have no Polish personal identification number PESEL:
 Passport series and number _____ Nationality (Country) _____

Phone number _____

Email address _____

Address of residence in Poland ☐ None ☐ Same address of residence as the patient's ☐ Other address of residence than the patient's:

Street _____ Building number _____ Flat number _____

Postal code _____ Town / City _____

FEBUMED Sp. z o.o. with its registered office in Warsaw at ul. Zygmunt Modzelewskiego 77 (02-679 Warszawa), entered in the register of entrepreneurs kept by the District Court for the Capital City of Warsaw in Warsaw under KRS number 0000962300, as data controller, informs you that your personal data – to the extent provided in the patient registration form – are collected for the purpose of providing medical services.
 You have the right to review and update the content of these data. The provision of data is voluntary, but the data are necessary for the proper performance of the services.

I hereby give my consent to FEBUMED Sp. z o.o. to send me information (confirmation, cancellation, rescheduling) about my ward's planned medical appointments, examinations, and treatments by means of electronic communication (via email and/or phone, also via text messages – only to a Polish phone number).



Name and surname of the patient: _____ PESEL

☐ I hereby consent ☐ I hereby do not consent to sending the results of my ward's examinations and/or my ward's medical records electronically to the **email address(es)** indicated above.

I declare that I have been informed that the personal data I have provided will be processed by FEBUMED sp. z o. o., in accordance with the information clause for FEBUMED patients provided to me in accordance with Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data and repealing Directive 95/46/EC, hereinafter referred to as: "GDPR". The text of the clause is available at the reception desks of FEBUMED medical facilities and online at: www.febumed.pl/polityka-prywatnosci

At the same time, I declare that

- ☐ I am the patient's legal guardian and I have obtained the consent of the other legal guardian to provide his/her data or
☐ I am the patient's sole legal guardian.

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Date of signature

 Legible signature of the legal guardian registering the patient

MARKETING CONSENTS

☐ I hereby consent ☐ I hereby do not consent to the processing of the **phone number(s)** I have indicated above for marketing purposes, including to inform me of new products/services and promotions from FEBUMED.

☐ I hereby consent ☐ I hereby do not consent to the processing of the **email address(es)** I have indicated above for marketing purposes, including to inform me of new products/services and promotions from FEBUMED.

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Date of signature

 Legible signature of the legal guardian registering the patient

AUTHORISATIONS GIVEN BY A LEGAL GUARDIAN OF A MINOR PATIENT

for patient appointments in the presence of a de facto carer, e.g. grandmother, grandfather, nanny, etc. (applies to patients aged 0-18 years), in order to carry out medical consultations, diagnostic tests without interfering with the patient's bodily integrity, the collection of blood and/or bodily secretions, allergen immunotherapy (after prior written consent expressed by the legal guardian) and the issuing of medical opinions and certificates.

At the same time, I am aware that **all treatments can only be carried out in the presence of a legal guardian.**

Name and surname of the de facto carer (if applicable) _____

Date of birth of the de facto carer (if applicable) --

Phone number of the de facto carer (if applicable) _____

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Date of signature

 Legible signature of the legal guardian registering the patient

TO BE FILLED IN BY THE FEBUMED EMPLOYEE

I declare that the signatures affixed in my presence are authentic

 (Date of employee's signature)

 (Legible signature of the employee)

