SophiaHealth®
INSTITUT KAUFBEUREN

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POTENTIAL PATIENT QUESTIONNAIRE

ANSWERS WILL BE KEPT STRICTLY CONFIDENTIAL

Name of Patient: ☐ M ☐ F	**DOB:**
Full Address:	
Email:	
Phone Number:	
For Children Name of Parents:	

Diagnosis		
Year	Diagnosis	Medication taken

Allergies

Additional information (free writing space)

Data Protection: The security of your Personal Information is important to us. We only use your Personal Information for contacting and identifying you regarding a potential treatment. By filling out and sending back this form you agree to the use of your data. For more information visit our website www.sophiahealth.de. If you have any questions about this Privacy Policy, please contact us.