Kinderwunschzentrum
Medical Excellence Austria Ambulatorium Döbling

Initial consultation

Please send us your completed PDF form and any test results, if applicable and available, no later than **one week before your appointment** by fax to +43 1 360 66-5060, by mail, or by email to kinderwunschzentrum@pkd.at.

FEMALE PARTNER

Titles	
First name*	
Last name*	
Date of birth*	
Place of birth	
Nationality	
Occupation	
Marital status*	
Telephone*	
Email*	
Street address	
Zip code Town	
State	

Insurance

☐ I am covered by compulsory social insurance in Austria.

Health insurance fund*	
Insurance number (e-card)*	

☐ I have private special class (Sonderklasse) supplementary insurance.

Health insurance company*	
Policy number*	

MALE PARTNER

Titles	
First name*	
Last name*	
Date of birth*	
Place of birth	
Nationality	
Occupation	
Marital status*	
Telephone*	
Email*	
Street address	
Zip code Town	
State	

Insurance

☐ I am covered by compulsory social insurance in Austria.

Health insurance fund*	
Insurance number (e-card)*	

☐ I have private special class (Sonderklasse) supplementary insurance.

Health insurance company*	
Policy number*	

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A PremiQaMed Group Company

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kinderwunschzentrum@pkd.at
www.kinderwunschzentrum-doebling.at

Female partner / Insurance / continued

☐ I will pay for services directly (no private special class supplementary insurance).

Male partner / Insurance / continued

☐ I will pay for services directly (no private special class supplementary insurance).

REFERRING PHYSICIANS

Primary care physician	
Gynecologist	
Urologist	

Is there anything else you'd like to tell us about?	

☐ **Statement of consent with regard to the use of data:**

I authorize PremiQaMed Ambulatorien GmbH (Döbling Outpatient Center – Fertility Center) to use the information I have provided above for the purposes of completing my registration for an initial consultation. I may revoke this authorization at any time by sending an email to kinderwunschzentrum@pkd.at.