DIAGNOSTIKI ATHINON
Clinical & Research Laboratory

NEW PATIENT FORM

(Please fill all the requested information with **CAPITAL Letters**)

DATE:	PATIENT No/VISIT ID: /
SURNAME:	
NAME:	
GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH:
PASSPORT/INSURANCE Nr.:	
ADDRESS(STREET/CODE/CITY):	
PHONE NUMBER:	
MOBILE PHONE:	
E-MAIL:	
THERAPIST:	L.M.R.:
REQUISITION TESTS:_____	

KNOWN TRANSMITTED DISEASES

HEPATITIS B ☐ HEPATITIS C ☐ HIV ☐

Medical History		**MEDICATION YOU MIGHT BE ON**
DIABETES	☐	
ANAEMIA	☐	
ALLERGIES	☐	
HIGH CHOLESTEROL	☐	
THYROID DISFUNCTION	☐	

Medical History only for Covid-19 testing (until 2-3 weeks ago)	**YES**	**NO**
Previous infection with SARS-CoV-2	☐	☐
Contact with a confirmed case	☐	☐
Fever or flu-like symptoms	☐	☐
Diarrhea or gastrointestinal symptoms	☐	☐
Anosmia	☐	☐

INFORMATION - DECLARATION OF CONSENT FOR THE COLLECTION AND PROCESSING OF PERSONAL DATA

Medical doctor Vassilis Sideris who maintains the Research & Microbiological Laboratory with the distinctive title "Diagnostiki Athinon" based in Athens, 6 Mesogeion Avenue, Athens, phone 210-7777654 e-mail info@athenslab.gr according to the provisions of Regulation 2016/679 and Directive 95/46/EC on the protection of personal data shall, in the capacity of controller, inform the person signing this declaration of the following:

a. The personal data contained in the New Patient Form are the following: SURNAME, NAME, FATHER NAME, DATE OF BIRTH, AMKA, ADDRESS (AREA / PC), MOBILE PHONE, PHONE NUMBER. The above data are used for matching of patient's samples, for medical reasons, for the issuance of tax documents, for the communication with the patient and the delivery of results.

b. The data "MEDICAL HISTORY", "MEDICINES you may receive", "TRANSMITTED DISEASES" are used exclusively for medical purposes and keeping a medical record.

c. NONE of the personal data is passed on to third parties unless requested by the patient.

EXCEPTION are the Mandatory Declared Diseases with absolute respect for your personal data and following the coded way of communication with EODY.

The patient has the following rights regarding his personal data:

1. Right of access to his/her data: The right to know if his/her data is being processed, how and for what purpose.
2. Right to correct his/her data: The right to request correction of his/her personal data if it is inaccurate or incomplete.
3. Right to delete his/her data: The right to request the deletion or remove of his/her personal data under certain conditions.
4. Right to restrict the processing of his/her personal data when certain conditions are met.
5. Right to the portability of his/her data. The patient's right to request that his/her data be sent to a third party (eg another doctor).

CONSENT

By signing this statement, the undersigned, whose full personal details are shown on the 1st page of this document, I declare that I am fully aware of , based on my free and unhindered decision, I agree, consent and give my express consent to the processing of all my personal data - as set forth in the New Patient Form for the purposes stated in this consent form. I know my right of access to the above data, the right to object to their processing as well as the withdrawal of my consent at any time.

Date …… Signature ……

DECLARATION FOR RECEIPT OF THE RESULTS OF MEDICAL EXAMINATIONS

By signing this statement, the undersigned, whose full personal details are shown on the 1st page of this document, I declare that I am fully aware of, based on my free and unhindered decision, I agree, consent and give my explicit consent to the receipt of the results of the medical tests:

- ☐ From …… .. with ID …… .... in printed form.
- ☐ Via e-mail to ……
- ☐ Post Office at …… ..
- ☐ By fax to …… ..
- ☐ Send to the e-mail of the Company / Organization ……

Date…… Signature……