Δρ. Γεώργιος Μαρκίδης CCT (UK)
Ειδικός Γενικός Χειρουργός & Χειρουργός Εντέρου - Ορθού
MBChB (Hons), PGCME, MFSTEd, MSc (Hons), FRCS (Gen Surg)

Dr Georgios Markides CCT (UK)
Consultant General & Colorectal Surgeon
MBChB (Hons), PGCME, MFSTEd, MSc (Hons), FRCS (Gen Surg)

Προηγμένη Ελάχιστα Επεμβατική,
Λαπαροσκοπική και Ρομποτική Χειρουργική

Advanced Minimally Invasive,
Laparoscopic & Robotic Surgery

Patient Personal Information

Patient name: ..... Gender: M / F

Date of Birth: ...../...../..... ID Number: ..... Language: .....

Home address: .....

Town: ..... Post Code: .....

Home Ph: ..... Work Ph: ..... Mob Ph: .....

Email address: .....

Occupation: .....

Employer: .....

Referring Clinician (if applicable): .....

Emergency contact: .....

Relation: ..... Phone (s): .....

Do you have private insurance? Yes / No

Name of Insurer: .....

Policy holder name: .....

Policy number: .....

For patients younger than 18 years old

Mother's name: .....

Date of Birth: ...../...../..... ID Number: ..... Mob Ph: .....

Email address: .....

Occupation: ..... Employer: .....

ARETAIEIO Νοσοκομείο:
Ανδρέα Αβραμίδη 55-57, Στρόβολος 2024, Λευκωσία - Κύπρος
T: 22-020728 | K: 99-848090 | Τηλ. Νοσοκομείου: 22-200300
info@drmarkides.com | www.drmarkides.com

ARETAEIO Hospital
55-57 Andreas Avraamides Str, Strovolos 2024, Nicosia-Cyprus
T: +357-22020728 | M: +357-99848090 | Hosp.: +357-22200300
info@drmarkides.com | www.drmarkides.com

Father's name: ……

Date of Birth: ……/……/…… ID Number: …… Mob Ph: ……..

Email address: ……

Occupation: …… Employer: ……

I authorize the following person(s) to receive my protected health information (such as family members):

Name: …….. Relation ……..

Name: …….. Relation ……..

Name: …….. Relation ……..

Authorization for services / Please read the following and sign at the bottom of this form.

I hereby authorize payments directly to the Physician, staff, or facility for medical services rendered. I understand I am responsible for any portion of my bill not covered by my insurance company, whether as a co-pay, co-insurance, deductible, or a non-covered service. I understand office co-pays are due at the time services are rendered. I also understand all the above and state that the information provided herein is true and correct to the best of my knowledge and will only be shared with medical professionals directly involved in my care.

Signature:…… Date: …… / …… / ……