PATIENT TEST CARD

SAMPLING DATE: …………………….

PRIVATE: ………………………………..

 COMPANY: ………………………………

**EMAIL** ……………………………………………… LANGUAGE : ……………................

YOU NEED IT FOR A JOURNEY? ❑ NO ❑ YES

 FLIGHT DATE……………………………………

YOU NEED TIME ❑ NO ❑ YES

|  |
| --- |
| FULL NAME  |
| NAME  |
| FATHER NAME |
| BIRTH DATE  |
| **ΑΜΚΑ (INSURANCE CAPACITY NUMBER)** |
| TELEPHONE NUMBER in GREECE |
| MOBILE NUMBER  |
| ADRESS or (HOTEL) |
|   |
| **ID NUMBER :** |
| **PASSPORT Number** |
| Rhinopharynx |
| ORALOPHYRGIC |
|  |
|  I consent to send me my results by email ❑ YES ❑ NO  |
| signature …………………………………………………… |