Patient labels

Admission Form for Patients

Type of admission

☐ Out-patient ☐ In-patient ☐ Out-patient day clinic (partial in-patient)

NOTIFICATION BY WHICH CLINIC | ADMISSION/TREATMENT DATE | ADMISSION/TREATMENT TIME

General Details

Personal details

SOCIAL SECURITY NUMBER/AHV (OLD AGE AND SURVIVORS' INSURANCE) NUMBER | INSURANCE CARD NUMBER

SURNAME | FIRST NAME | MAIDEN NAME

DATE OF BIRTH | GENDER ☐ Female ☐ Male | HOME TOWN/CANTON

OCCUPATION | LANGUAGE | NATIONALITY | RESIDENCE PERMIT

RELIGION/RELIGIOUS DENOMINATION ☐ Reformist ☐ Roman Catholic ☐ Other:

MARITAL STATUS ☐ Single ☐ Married ☐ Civil partnership ☐ Separated ☐ Divorced ☐ Widowed

Domicile/residential address for tax purposes

STREET/NUMBER | POSTCODE/TOWN OR VILLAGE | CANTON/STATE

TELEPHONE | MOBILE | E-MAIL

Other domicile/weekly commuter

RESIDENT C/O

STREET/NUMBER | POSTCODE/TOWN OR VILLAGE | CANTON/STATE

TELEPHONE | MOBILE | E-MAIL

Employer

NAME | TELEPHONE/MOBILE

STREET/NUMBER | POSTCODE/TOWN OR VILLAGE | CANTON/STATE

Contact person

☐ Spouse ☐ Civil partner ☐ Parents/parent ☐ Sibling ☐ Other:

SURNAME | FIRST NAME | TELEPHONE/MOBILE

STREET/NUMBER | POSTCODE/TOWN OR VILLAGE | CANTON/STATE

Collection of information from previous doctors and medical staff

The patient declares that he/she agrees to the UHZ collecting any medical information necessary for treatment from previous doctors and medical staff and releases said persons from their obligation of professional confidentiality in this context. ☐ Yes ☐ No

Please see overleaf

SURNAME FIRST NAME

Admission to hospital is due to

- ☐ Illness
- ☐ Accident
- ☐ Congenital defects
- ☐ Maternity
- ☐ Opinion for insurance
- ☐ Occupational illness

Your Insurance Details

Insurance cover

- ☐ General residential canton
- ☐ General throughout Switzerland
- ☐ Semi-private
- ☐ Private
- ☐ Self-payer

EXPECTED IN-PATIENT TREATMENT

- ☐ General
- ☐ Semi-private
- ☐ Private

Basic insurance

NAME OF INSURANCE COMPANY/TOWN OR VILLAGE

Additional insurance

NAME OF INSURANCE COMPANY/TOWN OR VILLAGE POLICY NUMBER

EXCLUSIONS

Accident/disability/military insurance

- ☐ Accident insurance
- ☐ Disability insurance
- ☐ Military insurance

NAME OF INSURANCE COMPANY/TOWN OR VILLAGE POLICY NUMBER

ACCIDENT NUMBER WORKS NUMBER

PLACE OF ACCIDENT DATE OF ACCIDENT

DISABILITY DECREE NUMBER

Name/address of your general practitioner

NAME TELEPHONE/MOBILE

STREET/NUMBER POSTCODE/TOWN OR VILLAGE

Name/address of the referring doctor

NAME TELEPHONE/MOBILE

STREET/NUMBER POSTCODE/TOWN OR VILLAGE

Have you ever been treated at the University Hospital of Zurich before?

☐ No ☐ Yes, which clinic?

Different billing address

SURNAME FIRST NAME

STREET/NUMBER POSTCODE/TOWN OR VILLAGE

Information about Admission

Section 24 of the „Tax Act of the University Hospital of Zurich of 25.3.2009“ requires the University Hospital of Zurich to check your personal details for your admission.

We therefore require:

- A valid identity card, passport, or current written confirmation of registration, which is available from the local residents' registration office. Non-Swiss nationals may also present their foreigner's identity card.
- An insurance card from the funding agency (health insurance, accident insurance, disability insurance, etc.).
- The notification letter from the clinic or the relevant admission documents from your referring doctor.
- This completed and signed admission form.

Cost assurance

The patient notes that he/she is liable to UHZ for the payment of the treatment requested by him/her. He/she confirms that he/she is aware of the extent of his/her insurance cover; the UHZ is not responsible for clarifying this. Should the UHZ have to seek clarification and should there be no comprehensive confirmation that the funding agency (insurance company/canton) will cover or refund the costs, the costs shall be invoiced to the patient. The patient cannot argue at a later date that he/she made a mistake or misjudged the insurance cover. In the event that there is no confirmation of the transfer of costs, the UHZ may request a deposit for the expected treatment costs.

The patient confirms the correctness of the data with his/her signature and gives his/her consent to the transmission of all data required for cost assurance and, if necessary, identity checks, to the relevant bodies (e.g. health fund, social security office). The data shall be transmitted in compliance with data protection requirements.

Research

I agree to my medical data being used for future research and teaching projects. In the case of transmission of data to third parties, my anonymity will be maintained at all times. I can withdraw my consent at any time.

☐ Yes ☐ No

Place

Date

Signature of patient
or his/her legal representative

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