

# 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

PATIENT DECREE?

Yes   
  No

### 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

SURNAME

FIRST NAME

### Admission to hospital is due to

- |   |  |
|---|--|
| <input type="checkbox"/> Illness            | <input type="checkbox"/> Maternity             |
| <input type="checkbox"/> Accident           | <input type="checkbox"/> Opinion for insurance |
| <input type="checkbox"/> Congenital defects | <input type="checkbox"/> Occupational illness  |

## Your Insurance Details

### Insurance cover

- |   |                                     |
|---|-------------------------------------|
| <input type="checkbox"/> General residential canton     | <input type="checkbox"/> Self-payer |
| <input type="checkbox"/> General throughout Switzerland |                                     |
| <input type="checkbox"/> Semi-private                   |                                     |
| <input type="checkbox"/> Private                        |                                     |

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

- |   |   |
|---|---|
| <input type="checkbox"/> Accident insurance   | <input type="checkbox"/> Military insurance |
| <input type="checkbox"/> Disability 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.

- Yes     No

Place

Date

Signature of patient  
or his/her legal representative

University Hospital of Zurich  
Head Office for Finance  
Rämistrasse 100  
8091 Zurich  
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