

Admission Form

PERSONAL DETAILS

Surname _____	Forename _____
Date of Birth _____	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
Street, No. _____	Telephone home _____
Address, Postcode (official domicile) _____	Telephone work _____
Home Town / Country of Origin _____	Job _____
Religion / Denomination <input type="checkbox"/> Rom. Cath. <input type="checkbox"/> Other _____ <input type="checkbox"/> Ref. <input type="checkbox"/> None	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Have you made a living will? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Occupation: <input type="checkbox"/> Self-employed <input type="checkbox"/> Employee	If unemployed, are you signing on? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employer (state in the event of an accident) _____	Full Address _____

Next of kin I wish the following person to be contacted in an emergency:

<input type="checkbox"/> Spouse / Partner	<input type="checkbox"/> Son / Daughter	<input type="checkbox"/> Mother / Father	<input type="checkbox"/> Sister / Brother	<input type="checkbox"/> Guardian	<input type="checkbox"/> _____
Name _____	Forename _____				
Full Address _____	Telephone _____				

FAMILY DOCTOR / REFERRING PHYSICIAN

Family doctor _____	City/Town/Village _____
Referring physician _____	City/Town/Village _____

REASON FOR REFERRAL / INSURANCE

<input type="checkbox"/> Illness / Birth: I have health insurance with: <div style="text-align: center;">↓</div> Health insurance company _____ Insurance number _____ Class of Insurance: Health <input type="checkbox"/> General residential canton <input type="checkbox"/> General for all of Switzerland <input type="checkbox"/> Semi-private <input type="checkbox"/> Private <input type="checkbox"/> Foreigner with no European Health Insurance Card	<input type="checkbox"/> Accident: I have accident insurance with: <div style="text-align: center;">↓</div> Accident insurance or health insurance company _____ Insurance number _____ Class of Insurance: Accident <input type="checkbox"/> General <input type="checkbox"/> Semi-private <input type="checkbox"/> Private <input type="checkbox"/> Foreigner with no European Health Insurance Card
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UPGRADES Due to the limited number of beds, a room upgrade cannot be guaranteed in advance.

I have general insurance and would like the following upgrade: <input type="checkbox"/> Room for 1 person A1 CHF 480 / night <input type="checkbox"/> Room for 2 persons A2 CHF 220 / night (except for Women's Clinic) <input type="checkbox"/> "Geburt Special" CHF 1800 flat	I have semi-private insurance and would like the following upgrade: <input type="checkbox"/> Room for 1 person HP CHF 360 / night <input type="checkbox"/> "Geburt Special" CHF 1200 flat
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IMPORTANT NOTE

If you do not have sufficient cover for your chosen class of insurance or your health insurance company subsequently refuses to defray the costs, all the costs that are not covered will be payable by you. I confirm that I have read and understood this information.

Date _____ Signature * _____

* If the form was completed by a representative: Forename, Surname _____