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ZUGER Kantonsspital

Admission Form

PERSONAL DETAILS

Surname _____ Forename _____

Date of Birth _____ Gender ☐ Female ☐ Male

Street, No. _____ Telephone home _____

Address, Postcode _____ Mobile _____

Home Town / Country of Origin _____ E-Mail _____

Religion / Denomination ☐ Rom. Cath. ☐ Ref. ☐ Moslem ☐ Hindu ☐ None ☐ Other _____

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Registered Partnership

Occupation: ☐ Self-employed ☐ Employee If unemployed, are you signing on? ☐ Yes ☐ 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:

☐ Spouse / Partner ☐ Son / Daughter ☐ Mother / Father ☐ Sister / Brother ☐ Guardian ☐ _____

Name _____ Forename _____

Full Address _____ Telephone _____

FAMILY DOCTOR / REFERRING PHYSICIAN

Family doctor _____ City/Town/Village _____

Referring physician _____ City/Town/Village _____

REASON FOR REFERRAL / INSURANCE

☐ **Illness / Birth:** I have health insurance with: ⇩

Health insurance company _____

Insurance number _____

Class of Insurance: Health
☐ General residential canton ☐ General for all of Switzerland
☐ Semi-private ☐ Private
☐ Foreigner with no European Health Insurance Card

☐ **Accident:** I have accident insurance with: ⇩

Accident insurance or health insurance company _____

Insurance number _____

Class of Insurance: Accident
☐ General
☐ Semi-private ☐ Private
☐ Foreigner with no European Health Insurance Card

UPGRADES

On the day of your admission, you have to make a deposit covering the expected time of your stay.
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:

☐ Room for 1 person A1 CHF 480 / night
☐ Room for 2 persons A2 CHF 220 / night (except for Women's Clinic)

I have **semi-private** insurance and would like the following upgrade:

☐ Room for 1 person HP CHF 360 / night

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 _____