PATIENT REGISTRATION FORM

GENERAL INFORMATION

Please complete this form in full and send it to the patient administration team of Zuger Kantonsspital **as soon as possible** before you are admitted to hospital or by email to pataufnahme@zgks.ch. In case of re-admission within 6 months, only provide your surname, first name, date of birth, referral/doctor's address and any amendments and complete the reverse side.

1. REASON FOR HOSPITALISATION

☐ Illness ☐ Accident, Date: …… **please report the accident immediately** (employer/insurance provider)

☐ Maternity ☐ Treatment not covered by mandatory health insurance ☐ Congenital defects ☐ Work-related illness

☐ Illness/accident in military service

2. PERSONAL DETAILS

Surname _____ Gender ☐ female ☐ male

First name _____ Date of Birth _____

Street, No. _____ Marital Status _____

Postcode, Place (official domicile) _____ Religion _____

Place/Country of Origin _____ Telephone,private _____

Email _____ Mobile _____

3. DO YOU HAVE A LIVING WILL? ☐ **No** ☐ **Yes (if yes, please bring along a copy of it when you are admitted)**

4. NEXT OF KIN Please contact the following person in the event of an emergency:

Next of kin

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

Surname, First Name _____ Telephone _____

Address, Place _____ ☐ same address as the patient

5. REFERRING DOCTOR / FAMILY DOCTOR (GP)

Referring doctor _____ Place _____

GP _____ Place _____

6. EMPLOYER

Surname _____ Place _____

Telephone _____ ☐ self-employed

please turn over and fill in and sign the following pages →

7. INSURANCE

Health insurance

807 | | | | | | | | | | | | | | | | | | | |

Name of insurance provider/Place Insurance card number (20 digits)

What type of insurance do you have?

☐ General ☐ Semi-private ☐ Private ☐ Generally throughout Switzerland ☐ Self-payer ☐ Elective insurance

Name of supplementary insurance provider/Place Insurance policy number

Accident/disability/military insurance

☐ Accident insurance ☐ Disability insurance ☐ Military insurance

What type of insurance do you have?

☐ General ☐ Semi-private ☐ Private

Name of insurance provider/Place UVG claim number

IV provision number Military insurance number

For inpatients: How would you like to be treated?

☐ General ☐ Semi-private ☐ Private Signature_____

INVOICE COPY

We are happy to send you a copy of your invoice as required by law. We do not send invoices by post in order to protect the environment. To enable us to send you both invoices and copies of invoices digitally, you agree to provide us with your email address and mobile phone number.

IMPORTANT

If you are not sufficiently insured for the selected insurance class or if the assumption of costs by your insurance provider is subsequently refused (in accordance with KVG, VVG, UVG, etc.), all uncovered costs will be borne by you.

CONSENT

I confirm that I have read and understood the information above.

Date / Place _____ Signature _____
Patient / Representative

☐ The form has been completed by the following representative:

Surname, First Name _____ Phone no.: _____

For the admission formalities, we require the completed and signed registration form (please send by post or email to pataufnahme@zgks.ch in advance).

DECLARATION OF CONSENT

I acknowledge and agree that

- my referring doctor, family doctor and, if applicable, other medical professionals involved in my treatment receive a report on my current treatment at Zuger Kantonsspital.
- the Zuger Kantonsspital may obtain the medical information necessary to carry out the treatment from my pre-treating doctors or hospitals and other medical personnel. I hereby release the pre-treating physicians and medical specialist teams from professional confidentiality.
- the legally required invoice copy is provided through a portal; the email address and mobile number are used for this purpose
- photos and video recordings may not show recognisable hospital staff for data protection reasons
- my consent is voluntary and that I have the right to withdraw this consent at any time. The withdrawal of consent applies with future effect and does not affect the lawfulness of the personal data processing prior to withdrawal of consent.

QUALITY ASSURANCE AND SCIENTIFIC ISSUES

It is conceivable that your treatment documentation may be used for quality assurance or scientific purposes. This will be done in anonymized or encrypted form and in compliance with data protection regulations. Please inform your doctor if you do not wish your treatment documentation to be included. Data is collected for the purpose of improving patient-oriented healthcare and for internal quality assurance, e.g. as part of surveys.

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ASSUMPTION OF COSTS

You acknowledge that you are liable to the hospital for the treatment you have requested. The prices set out in the tariff regulations for Zuger Kantonsspital are applicable according to the treatment year. You confirm that you are aware of the scope of your insurance cover; the hospital has no obligation to clarify this. In the event that the hospital provides clarification on a goodwill basis, and if no full cost approval and/or cost coverage from a service provider exists, the costs will be invoiced to you. By signing below, you declare that the information on the registration form is correct. You cannot subsequently claim that you made a mistake or wrongly estimated the insurance cover.

COMMITMENT

By signing below, you commit to pay the costs of the Zuger Kantonsspital. The payment deadline stated in the invoice from Zuger Kantonsspital is also the deadline for objections. By signing this form, you acknowledge that the invoice will become legally binding upon expiry of the deadline for objections. The place of jurisdiction is Baar. Swiss law applies.

IMPORTANT

If you are not sufficiently insured for the selected insurance class or if the assumption of costs by your insurance provider is subsequently refused (in accordance with KVG, VVG, UVG, etc.), all uncovered costs will be borne by you.

CONSENT

I confirm that I have read and understood the information above.

Date / Place _____ Signature _____

Patient / Representative

☐ The form has been completed by the following representative:

Surname, First Name _____ Phone no.: _____

Please sign and return this form in the enclosed reply envelope.
If you have any questions, please contact the patient admission team. They can be reached by calling the phone number +41 41 399 44 40 or by email at pataufnahme@zgks.ch.