SPORT CLINIC ZURICH
www.sportclinic.ch

Patient admission form

SportClinic Zurich

Klinik Hirslanden
Witellikerstrasse 40, P.O. Box
8032 Zurich
Tel 044 387 29 77
Fax 044 387 29 88
chirurgie@sportclinic.ch

Surgery

Personal information

Family name ____________________
____
Minors: Family and first name of parent

First name ____________________
Profession ____________________
Address ____________________
Title ____________________
Zip/Postcode ____________________
Date of birth ____________________
City address ____________________
Nationality ____________________
Private telephone no. ____________________
E-mail ____________________
Mobile telephone no. ____________________
Family doctor ____________________
Business telephone no. ____________________
____
First and Family name, Address

Referral or recommendation by

Family doctor Specialist doctor Other ____________________
First and Family name, City address

SportClinic Klinik Hirslanden
SportClinic Sihlcity
SportClinic Tödistrasse
SportClinic Seebahnstrasse
SportClinic Stadion Letzigrund
SportClinic Puls 5

Physiotherapy
Other patient
Internet
Club or training staff
Media
Various

Health service

Name, Location of registered office ____________________
____
OASI (AHV) no. ____________________

General department
Hospital insurance, semi-private
Hospital insurance, private
Incl. accident insurance Yes No

Supplementary insurance

Name, Location of registered office ____________________
____
OASI (AHV) no. ____________________

Illness Semi-private Private
Accident Semi-private Private

Accident insurance or IV/MVG

Name, Location of registered office ____________________
____
Accident no. ____________________

Date of accident ____________________
General Semi-private Private

Continued overleaf

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Sports performance level

Please tick the box for your performance level:

No sports	0
Sports for fitness (once or twice a week)	9
Hobby sports (regular, up to three times a week)	8
Competitive sports	7
Other intensive sports activity	6
League 1 or 2	5
League Nati A or B	4
Performance sports in a junior national team	3
Performance sports in a national team	2
Performance sports in the Swiss Olympic team	1

Main sports disciplines ______________________________

Sports club ______________________________

I am aware that my attending physician will be entitled to ask for my patient records as could involve my illness from other doctors or medical institutions if this will save on unnecessary additional costs and examinations.
In my own interest, I hereby grant my attending physician my consent to send his or her examination or treatment findings to any subsequent attending or referring physician.

I hereby grant my consent for any information as necessary for billing to be sent to the party involved (such as the insurance company) or to any organisation charged with collecting outstanding debt and its legal representatives, or to any state organisation involved. Furthermore, I hereby give permission that the invoice for my examination is to be sent directly to the health insurance company.

I am aware that my medical records will be electronically managed and stored.

I am aware that charges will be billed privately if I should fail to cancel an appointment at least twenty-four hours beforehand.

I hereby give my consent for my medical data to be analysed for scientific purposes (the data are analysed anonymously).

Date ______________________________

Signature ______________________________

Please complete and return this form by fax to 044 387 29 88, or by e-mail to chirurgie@sportclinic.ch
SportClinic Zurich, Surgery