SPORT CLINIC ZURICH
www.sportclinic.ch

Patient admission form

SportClinic Zurich

Puls 5
Giessereistrasse 18
8005 Zurich
Tel 044 274 88 88
Fax 044 274 88 89
medizinp5@sportclinic.ch

Medicine

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

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.

Date ______________________

Signature ______________________

**Please complete and return this form by fax to 044 274 88 89, or by e-mail to medizinp5@sportclinic.ch
SportClinic Zurich, Medicine**