

Patient admission form

SportClinic Zurich

Tödistrasse
Tödistrasse 49
8002 Zürich
Tel 044 209 60 30
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medizin@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	_____			
	SportClinic Klinik Hirslanden			Physiotherapy			
	SportClinic Sihlcity			Other patient			
	SportClinic Tödistrasse			Internet			
	SportClinic Seebahnstrasse			Club or training staff			
	SportClinic Stadion Letzigrund			Media			
	SportClinic Puls 5			Various			
Health service	Name, Location of registered office	_____			General department		
	_____	_____			Hospital insurance, semi-private		
	OASI (AHV) no.	_____			Hospital insurance, private		
Supplementary insurance	Name, Location of registered office	_____			Incl. accident insurance	Yes	No
	_____	Illness	Semi-private	Private			
	_____	Accident	Semi-private	Private			
	OASI (AHV) no.	_____					
Accident insurance or IV/MVG	Name, Location of registered office	_____			Date of accident	_____	
	_____	General	Semi-private	Private			
	Accident no.	_____					

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 _____