

## Admission Form

For inpatients/outpatients. Please fill out and send/bring back.

### Personal details

Male  Female

First name \_\_\_\_\_

Surname \_\_\_\_\_

Maiden name \_\_\_\_\_

Date of birth (month/day/year) \_\_\_\_\_

OASI number \_\_\_\_\_

Place of birth/Nationality \_\_\_\_\_

Telephone/cell Phone \_\_\_\_\_

E-mail \_\_\_\_\_

### Place of taxation

Street/no. \_\_\_\_\_

Zip code/place \_\_\_\_\_

Canton \_\_\_\_\_

### Other place of residence/address

C/O \_\_\_\_\_

Street/no. \_\_\_\_\_

Zip code/place \_\_\_\_\_

### Marital status

Single  Divorced

Married  Separated

Widowed  In a registered civil partnership

### Religion

Roman Catholic  No religious affiliations

Protestant  Orthodox

Muslim  Not specified

Other \_\_\_\_\_

### Contact person

First name \_\_\_\_\_

Surname \_\_\_\_\_

Date of birth (month/day/year) \_\_\_\_\_

Street/no. \_\_\_\_\_

Zip code/place \_\_\_\_\_

Telephone/cell Phone \_\_\_\_\_

### Relationship with the contact person

Acquaintance  Mother/father

Caregiver  Neighbor

Spouse  Nephew/niece

Grandchild  Son-/daughter-in-law

Friend  Son/daughter

Sibling  Partner

### Reason for admission to hospital

Illness  Pregnancy

Accident – indicate date of accident \_\_\_\_\_

### Type of stay

Outpatient  Inpatient

### Medical center

Medicine  Gynecological medical center

Surgery  Admission date \_\_\_\_\_

### Preferred inpatient treatment

General  Family room (for births)\*

Semi-private  Upgrade to semi-private\*

Private  Upgrade to private\*

\* Additional fee.

### Your insurance details

General, in canton of residence  Semi-private

General, throughout Switzerland  Private

Optional surgery/private patient

### Health insurance

Name of basic insurance \_\_\_\_\_

Insurance card no. \_\_\_\_\_

Name of additional insurance \_\_\_\_\_

Insurance card no. \_\_\_\_\_

### Accident insurance (only to be filled out for accidents)

Name of basic insurance \_\_\_\_\_

Name of additional insurance \_\_\_\_\_

Claim no. \_\_\_\_\_

### Employer (only to be filled out for accidents)

Company \_\_\_\_\_

Zip code/place \_\_\_\_\_

Self-employed  Pupil/student

Homemaker  Pensioner

Unemployed  Unemployed (registered with the RAV)

### General Practitioner

Name \_\_\_\_\_

Zip code/place \_\_\_\_\_

No General Practitioner

### Doctor requesting hospitalization

Name \_\_\_\_\_

Zip code/place \_\_\_\_\_

### Doctor treating patient

Name \_\_\_\_\_

Zip code/place \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

Please also fill out the page overleaf

**I hereby confirm that the details I have provided on page one are correct.**

I understand that any costs not covered by my health insurance provider/accident insurance must be paid for by the patient or their legal representative.

I accept the general terms and conditions of the Spital Lachen AG.

I understand and agree that:

1. The doctor hospitalizing me, my General Practitioner, and any further doctors or insurers involved will receive my personal and medical details. I can, however, explicitly request the Spital Lachen to disclose the medical details to my health insurance provider's medical consultant.
2. The medical and health professionals and partners of the Spital Lachen who are involved in my treatment can access my medical files.
3. The Spital Lachen can retrieve and save data directly from my insurance card or via databases offered by the insurance providers.
4. Sensitive data sent by e-mail could potentially be intercepted and misused. Please note that the Spital Lachen cannot guarantee secure data transmission by e-mail. By disclosing my e-mail address, I, the signed patient, authorize the Spital Lachen to communicate with me via unencrypted e-mail unless otherwise stated.
5. The Spital Lachen can forward open claims and pass on necessary data for such cases to an external debt collection agency.

6. The Spital Lachen can neither be held responsible nor liable for any personal property, valuables, or money the patient brings with them.

Place and date

---

Legally binding signature

---

- The place of jurisdiction is the registered office of the Spital Lachen AG.
- We would ask any patients requesting additional services (for example, semi-private or private treatment, a higher room category, etc.) to also fill out the corresponding form.
- Copies of invoices can be requested at the hospital.