PERSONAL INFORMATION

HIRSLANDEN
KLINIK BIRSHOF

PLEASE RETURN THE FORM TO THE FOLLOWING ADDRESS: BIRSHOF.EMPFANG@HIRSLANDEN.CH

☐ **MRS/MS** ☐ **MR**

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____ E-MAIL _____

STREET AND NO. _____ TAX CANTON _____

POSTCODE AND PLACE OF RESIDENCE _____ MARITAL STATUS _____

NATIONALITY _____ MOBILE NO. _____ TELEPHONE (H) _____

TELEPHONE (W) _____ AHV NO. _____

FAMILY DOCTOR (ADDRESS) _____

REFERRING DOCTOR _____

Please ensure that you provide the contact details of your specialist and your family doctor so that the hospital can inform them about your stay.

REFERRED BY
☐ SPECIALIST ☐ FAMILY DOCTOR ☐ SELF-REFERRAL

DO YOU WISH YOUR FAMILY DOCTOR TO BE INFORMED? ☐ YES ☐ NO

TREATED BY _____ BODY PART _____

☐ **ILLNESS**

BASIC HEALTH INSURANCE COMPANY ☐ GENERAL CANTON OF RESIDENCE ☐ GENERAL SWITZERLAND-WIDE

NAME / ADDRESS _____

POLICY NO. _____

CARD NUMBER 8 0 7 5 6 ⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋⌊_⌋ (This information can be found on the insurance card)

SUPPLEMENTARY HEALTH INSURANCE COMPANY ☐ SEMI-PRIVATE ☐ PRIVATE

NAME / ADDRESS _____

POLICY NO. _____

☐ **ACCIDENT** ☐ I have already reported the accident/relapse to my insurance company.

COMPULSORY ACCIDENT INSURANCE COMPANY ☐ GENERAL

NAME / ADDRESS _____

INJURY NO. _____ POLICY NO. _____

DATE OF ACCIDENT _____

SUPPLEMENTARY ACCIDENT INSURANCE COMPANY ☐ SEMI-PRIVATE ☐ PRIVATE

NAME / ADDRESS _____

INJURY NO. _____ POLICY NO. _____

Please also provide us with the contact details of your health insurance company if the costs are to be borne by the compulsory accident insurance.

OCCUPATIONAL ACTIVITY

OCCUPATION _____

NAME / ADDRESS OF YOUR EMPLOYER _____

DO YOU WORK MORE THAN 8 HOURS PER WEEK? ☐ YES ☐ NO

BUSINESS ADDRESS FOR SELF-EMPLOYED PEOPLE _____

NEXT OF KIN/LEGAL REPRESENTATION Person who may be privy to information in cases of need/emergency.

RELATIONSHIP _____

LAST NAME _____ FIRST NAME _____

ADDRESS/POSTCODE/PLACE OF RESIDENCE _____

TELEPHONE (H) _____ TELEPHONE (W) _____

Please turn the page.

PLEASE NOTE

You are registered for inpatient treatment at Klinik Birshof. Klinik Birshof is staffed by affiliated doctors. Your medical treatment is usually carried out by self-employed doctors who are independently responsible for you.

ASSUMPTION OF COSTS / INSURANCE PROTECTION

Your treatment is usually invoiced electronically to your health insurance company, accident insurance company or the Ärztkasse insurance fund. If you do not wish this to happen, please inform us at reception.

Please ensure that you are fully aware of what type of insurance protection you have. You cannot make a claim at a later date by saying that you wrongly assessed your insurance protection. If the costs for your hospital stay and/or treatment are not covered or only partially covered by your insurance, you will be required to cover the outstanding costs yourself. If you do not provide Klinik Birshof with evidence that you have sufficient insurance cover prior to a specific procedure, the hospital can request a deposit or deny you treatment.

LIABILITY

Please note in particular that Klinik Birshof cannot accept liability for items lost or stolen during your hospital stay, nor for damages resulting to belongings after treatment.

PATIENT CONFIDENTIALITY / DATA PROCESSING

The participating doctors and medical specialists must have access to and share certain patient data to provide the best possible care during your hospital stay. Klinik Birshof is also dependent on being able to process or forward patient information in accordance with the requisite legal or administrative requirements. The hospital is legally obligated to submit the patient's medical information on diagnoses and treatments to the insurer for auditing purposes. The patient may request at any time that their medical information is only provided to the medical officer. Your personal information and invoicing information may also need to be forwarded to third parties in connection with the invoicing procedure/ collection of payment. Finally, Klinik Birshof monitors the quality of its services on an ongoing basis while providing services to its patients. The hospital periodically commissions a widely recognised Swiss healthcare institute to conduct written surveys. To some extent, these submissions are determined by the authorities. People outside the hospital cannot identify the respective patient. With this in mind, you agree to your data being processed or passed on as described above.

The above-mentioned information relates to all outpatient cases and only becomes invalid once you have withdrawn it.

The place of jurisdiction is Basel-Landschaft.

By signing this form, I confirm that I have read and accepted the above-mentioned conditions.

Place, date _____ Signature _____