Kantonsspital St.Gallen

Kantonsspital St.Gallen
CH-9007 St.Gallen
Tel. +41 71 494 11 11
www.kssg.ch

Personal details

- **Please return this questionnaire in the enclosed envelope.**
- **If you have already been treated at St.Gallen Cantonal Hospital in this calendar year, only fields marked with a * must be completed.**

Admission* ☐ Inpatient ☐ Outpatient ☐ St.Gallen ☐ Rorschach ☐ Flawil

Date of admission/ time:* _____ Clinic:* _____

Reason for admission: ☐ Illness ☐ Accident ☐ Pregnancy

Reason for treatment:* _____

_____

Name of patient* _____ Gender ☐ male ☐ female

First name* _____ Date of birth* _____

Name at birth _____ Private telephone _____

Social security number (AHV-no.)* _____ Business telephone _____

Mobile telephone _____

Street/house no. _____ Nationality _____

Zip code/town _____ Marital status _____

Tax authority _____ Religious denomination _____

Email address _____ ☐ I consent to the transfer of data to the on-site pastoral care service

Occupation _____ Place of citizen ship _____

Contact person ☐ Spouse ☐ Partner ☐ Sibling ☐ Parent ☐ Child ☐ Friend ☐ Other

_____

_____

(Please enter full name, address and telephone number)

Employer Please specify only in the event of an accident Date of accident: _____

_____

(Please enter full name and address)

Referring physician* ☐ Physician ☐ Rescue service ☐ Self-referral ☐ Hospital

_____

(Please enter full name and address)

Family doctor*

_____

(Please enter full name and address)

Insurance* Name of insurance provider/zip code/town **Insurance and card number**

Basic insurance _____

Supplementaryinsurance _____

Accident insurance _____

Coverage ☐ **Private** ☐ **Semi-private** ☐ **General ward in canton of residence** ☐ **General ward throughout Switzerland**

Please sign the form overleaf.

I hereby confirm the accuracy of the information provided on page 1 and undertake to pay any costs not covered by insurance myself.

I understand and agree that:

- The referring physician, the primary care physician, any other physicians involved and participating insurance companies will receive my personal details and medical data, and I can expressly request that the hospital transfer the medical information to the insurance company's medical officer.
- The healthcare professionals involved in my medical care and their medical assistants within the four hospital networks of the canton of St.Gallen and St.Gallen Geriatric Clinic can access my medical records. This consent also applies to records from the Center for Laboratory Medicine.
- The hospital can pass on outstanding claims, as well as the necessary data relating to these claims, to an external debt collection agency.
- The hospital assumes no responsibility or liability for personal effects, valuable items or cash brought onto the premises.
- Sensitive data can, in some circumstances, be intercepted during email transmission and/or communication by mobile phone and/or SMS and subsequently misused. Please note that the hospital is unable to guarantee the secure transmission of emails and/or SMS messages. By signing this document, I confirm that I agree to direct and unencrypted communication with the hospital by email and/or mobile phone and/or SMS. I can withdraw this consent at any time.
- The hospital can retrieve and store data directly from my health insurance card or from the databases provided by the insurance companies.

Place of jurisdiction: St.Gallen

Obtaining information from previous attending physicians and medical personnel

I hereby agree that St.Gallen Cantonal Hospital can contact the previous attending physicians:

_____

(Please enter full name and location)

and other previous attending medical personnel:

_____

(Please enter full name and location)

to obtain the necessary medical information for carrying out treatment and accordingly relieve the stated individuals of their professional duty of confidentiality.

Place and date: _____

Legally valid signature: _____

(Patient or legal representative)

Patients wishing to receive additional services (e.g. a semi-private or private ward) are kindly requested to complete the corresponding additional form.

Copies of invoices can be ordered from the hospital.