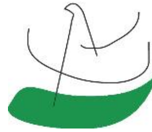

Spital Zollikerberg
Your specialist hospital in a natural setting

Augenzentrum Zollikerberg
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New patient registration form

(please complete in block capitals)

Surname: ____________________ **First name:** ____________________

Date of birth: ____

Address: ____

Occupation/title: ____

Home phone no.: ____________________ **Mobile phone no.:** ____________________

Email address: ____

We normally send important communications, such as the results of medical tests, by post. We can send them by email at your express instruction. However, please note that the email content will be sent in unencrypted form, which means it is not protected against access by third parties. Emails can in theory be read by email providers and other parties.

☐ I have read the data protection information and still wish to receive correspondence by email.

Your GP (name and practice address): ____

Previous or personal eye specialist (name and practice/clinic address):

____

For children: Surname/first name of mother, father or legal guardian:

____

☐ Address as above (if other, please state below)

Further information: Relative, parental figure, patient advocate, specific invoicing address:

____

____

Name of health insurance company/agency: ____________________

☐ Invoice to the health insurer ☐ Provide patient with copy of invoice
☐ Invoice to the patient

I hereby authorise the doctors of Augenzentrum Zollikerberg to request any medical records that may relate to my condition from other doctors or medical institutions in order to avoid performing the same examinations again unnecessarily, thereby saving costs.

In my own interests I also agree that they may forward the results of my examinations and treatments to other doctors treating me, to doctors providing me with further treatment and/or to referring doctors.

The invoice will be issued by the Spital Zollikerberg administration team, which holds my data.

Place, date: ____________________ **Signature:** ____________________