Patient registration form

Ärztezentrum Sihlcity

Last name		**Gender**	
First name		**Language**	
Address		**Private phone**	
Zip-Code	**Land/City**	**Mobile**	
Date of birth		**email**	

For person underage name and address of parents

Insurance
Insurance-Nr

Employer	**Phone**
Profession	**Location**

General practitioner (first and last name)
Location

Comment

In case a doctor at the Aerztezentrum Sihlcity needs further medical information from another institution I give the permission to send copies to the Aerztezentrum Sihlcity. The Aerztezentrum Sihlcity has an electronic patient medical chart. I agree that doctors of the Aerztezentrum Sihlcity have access to the documentation of their colleagues. We also send your contact details to the institution we work together.

I agree that in case of a third warning for a not paid bill the reminder charges will be invoiced to me. I acknowledge that in case of Inkasso-procedure the necessary information will be forwarded to FMH inkas.

Place of jurisdiction is Zurich.

Date: Signature:

Please turn

Accounting System Ärztezentrum Sihlcity

A Tiers payant (Regular way)

The Aerztezentrum Sihlcity sends the bill to the insurance. They will pay directly to the Aerztezentrum. You will have to pay only your participation (franchise, etc.) to your insurance.

☐ I agree with the direct account with the insurance. I will receive a link by email to get a copy of the bill.

In order to be able to send you the documents by mail, it is important that we have your current mail address and cell phone number. Please inform us about any changes as soon as possible.

B Tiers garant

You pay the bill directly to the Aerztezentrum Sihlcity and send a reclaim-document to your insurance.

☐ I choose this billing system, receive the invoice by e-mail and pay the bills myself.

In order to be able to send you the documents by mail, it is important that we have your current mail address and cell phone number. Please inform us about any changes as soon as possible.