Klinik Arlesheim

Admission for inpatient stay

Please fill in this form completely. Thank you.

Last name	Maiden name	First name
Address	Postal code/City	Date of birth
Phone	Mobile Phone	E-Mail

☐ F ☐ M

Marital status	Religion	Nationality	Profession

Person to be called in case of emergency (legal representative) Name, domicile, phone

Family physician (Name, address, phone)

Physician who refers you to the Klinik Arlesheim (Name, address, phone)

Bank transfer details (Account, IBAN Nr., BIC/ Swift)

Desired room category

☐ 2 beds ☐ Single room

How did you find our clinic?

☐ Relatives/ Friend ☐ Physician ☐ Internet ☐ Advertisement ☐ Other

Date of admission_____

I have taken note of the conditions for admission of the Klinik Arlesheim and, if there is no guarantee by E112/S 2, I consent to cover the total prospective costs of the stay by a prepayment.

Date_____ Signature_____

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