CLINIQUE du PRÉ
Une seule exigence, l'excellence

Patient information form

This document MUST be brought back complete during admission as not to delay the admission process

Surname : ………………………………………………………………… **Maiden Name :** …………………………………………………

First Name : ………………………………………………………………… **Date of Birth :** …………………………………………………..

Email Adress : ………………………………………………………… **@**……………………………………..

Emergency contact information :

Surname and name : ………………………………………………………… Family relationship : ………………………………………………
Adress : ……
Phone No : ………………………………………………/…………………………………………….

Person of trust :

I, (surname, first name, family relationship)………………………………………………………………………………………………
agree to be the person of trust (surname, first name)………………………………………………………………………………
Adress : ……
Phone : ……………………………………………………………………/……………………………………………………………………….
(You can find information pertaining to the Person of Trust in the Clinic's Welcome booklet)
Date : Signature :

Permission to operate on minors :

- A Signature form both parents/guardians is required. If one of the parents is has no parental authority over the minor, legal proof is necessary
- Please bring a photocopy of the family records book

We (surname, name family relationship)
……………………………………………………………………………………
……………………………………………………………………………………
……………………………………………………………………………………
……………………………………………………………………………………
Fully authorize an operation on (surname, name)
……………………………………………………………………………………
Date : Signatures :

Permission to operate on adults under guardianship (if the patient is unable to make decisions pertaining to their health) :

I, (surname, first name, relationship)
……………………………………………………………………………………,
Fully authorize an operation on (surname, first name)
……………………………………………………………………………………
Date : Signature :

Other Directives or Wishes :

Do you have any wishes or directives ? YES ☐ NO ☐
(You may find information on possible wishes, directives, donor options etc…in the Clinic's Welcome Booklet)
If yes, please give a copy to the nurse to put with your file.

If you are having an outpatient operation :

The day's procedures have been explained to me, and I have understood and accepted : ☐ YES ☐ No

An accompanying adult must be present at the home until the day after the operation:

Surname and Name : ………………………………………………… Family relationship: ……………………………………………………

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Patient's General Practitioner :

Surname and first name: ………………………………………………………… Phone : …………………………………………………………
Adress : ……

Your operation is related to :

☐ A work accident ☐ A professional illness ☐ None of these

Confidentiality :

Do you wish that your stay in the clinic remains confidential (only persons on a given list may contact you during your stay) ?
☐ YES ☐ NO

Permission (please tick the boxes that suit) :

I, (surname and name)……………………………………………………………………………………….agree,

- ☐ Not allow the clinic to purchase all refundable treatment materiel, blood or blood-derived products which may be used in my treatment, in my stead.
- ☐ Not allow the clinic to take all necessary blood tests, in case of blood exposure suffered by the medical staff charged with your treatment and stay.
- ☐ Not allow a picture of me to used in the clinic's electronic patient file. This is to assure quality and securite of the stay, and to prevent risks of identity mistakes.
- ☐ Not allow a student (nurse, medical assistant), supervised by a medical professional of the corresponding profession, to give medical aid throughout my treatment.
- ☐ If necessary, not allow my patient information to be shared with other medical professionals to improve my quality of treatment (CNIL).

I'm informed that further and necessary biological testes helping ensure the success of my treatment might be done.
They may be subject to an excess to paid, refunded by some mutual funds.

Signature :

Payment information :

I would like to choose

- a particular room during the term of my stay
  (Price : €70/day while hospitalized, €30 day if an outpatient) ☐ YES ☐ NO
- A Serenity room (Price : €85/day ensuring a particular room for the term of my stay) ☐ YES ☐ NO
- A double room ☐ YES ☐ NO

I have been informed on the price of the particular room, and I have guaranteed that I am covered by my insurance.

I have been fully informed of, and I will pay upon the day of my departure, the full cost (medical costs, costs of staying, other possible costs, etc.) not covered by my insurance or social security.

Date : Signature :