

**P. D. HINDUJA NATIONAL HOSPITAL &
MEDICAL RESEARCH CENTRE**
(Established and managed by the National Health & Education Society)



VEER SAVARKAR MARG, MAHIM, MUMBAI-400 016, INDIA • PHONE: 2445 1515, 2445 2222, 24449199 • FAX: 2444 9151

NEW PATIENT REGISTRATION FORM
(To be filled in English)

HH NO.

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(To be filled by hospital staff)

If the patient has a Hinduja Hospital (HH) card number (taken in OPD/Health Check up/Casualty/Admission) please DO NOT fill this form, kindly inform the counter staff to find your HH number.

Date :

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 dd

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 mm 20

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 yy

NAME : _____
LAST (SURNAME) FIRST MIDDLE
DATE OF BIRTH: ____/____/____ AGE: _____ YEAR/MONTH/DAY
dd mm yy
MARRIED / SINGLE MALE / FEMALE OCCUPATION _____

RESI. ADDRESS: _____

PIN CODE:

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TEL. NO.: _____ RES : _____ OFFICE : _____ FAX : _____
E.MAIL: _____ MOBILE: _____

RESPONSIBLE PERSON DETAILS

RELATION : FATHER/ MOTHER/ HUSBAND/ WIFE/ OTHERS _____

LAST NAME FIRST NAME MIDDLE NAME
CONSULTANT/DOCTOR NAME: _____
REFERRING DOCTOR'S NAME: _____

I understand that my medical record will be destroyed 3 years after my last visit to this hospital.

SIGNATURE: _____ NAME: _____

GENERAL CONSENT

- I/ We agree for the patient to undergo examination, investigations and treatment as decided by the hospital and also to abide by its schedule of charges, rules and regulations (available at registration counter).
- I authorize Mr./Ms. _____ to take decision on my behalf in case of my inability to do so due to associated medical condition.
- I understand that I have to disclose my clinical history and other relevant information to the healthcare provider team required for the management of my disease.
- I am fully aware that the medical treatment may be extended beyond the expected period at the discretion of the doctor.
- If my financial credit status is disputed by credit/insurance company/TPA, I undertake to settle the final bill on the date of discharge. I also undertake to make payment against interim bills raised within stipulated time.
- The doctor's discretion shall be considered as final for my discharge. I assent for transfer out from your hospital to other hospital/ nursing home in case of non-payment of bill/ discretion of doctor.
- I certify that I read the above and understand the contents. I further state that I have been given an opportunity to ask questions and all my questions have been answered fully and to my satisfaction.

Patient

Next-of-kin/accompanying person (Mention relationship)
(To be filled in case patient is not in a condition to sign)

Name: _____

Signature: _____

Date: _____

Patient ID: _____