**DATE:**      **TIME:**      **VESSEL:**

**FAMILY NAME:**                      **FIRST:**

**DOB:**            **AGE:**            **CABIN:**

**REASON FOR CONSULTATION: (*Please include all symptoms and when they commenced*)**

**New patient / Follow up (*please circle*)**

**PAST MEDICAL HISTORY:**

**If injury, have you injured this part of your body before: Y/N (*please circle*)**

**ALLERGIES:**

**CURRENT MEDICATIONS:**

**DECLARATION AND MEDICAL AUTHORIZATION:**

**I,**                     **, hereby authorize the medical staff and / or their agents, employees and representatives to conduct such treatments, procedures, administer anesthesia, medication and other therapies, with the exception of**                      **( if none, enter the word, NONE.), as they deem necessary in their medical judgement.**

**I understand that the medical care furnished to me will be limited to the type of care necessary, in the opinion of the medical staff and understand that whatever service is rendered is emergency treatment within the scope of the limited shipboard medical facility. I understand that the medical staff may be required to provide confidential medical information and or records of my medical treatment to others in the ordinary course of business and/ or comply with regulations of regulatory agencies. I hereby authorize such release of this information / records.**

**I acknowledge that the medical doctor and nurse are made available on the ship for my convenience. I understand and agree that full payment is due upon service rendered. I understand that although this bill may be submitted to my insurance carrier for consideration, I agree not to hold the Ship Owners, its ship, agents or employee’s responsible or liable for all or any portion of any charges not covered by my travel, health or other insurance carriers.**

**Signed:**                           **Date:**

**Patient’s Signature**

**Signed:**                           **Date:**

**Physicians Signature**