P. D. HINDUJA NATIONAL HOSPITAL AND MEDICAL RESEARCH CENTRE
(Established and managed by the National Health & Education Society)
Veer Savarkar Marg, Mahim, Mumbai- 400 016. Tel: 2444 9199, 2445 1515, 2445 2222 Fax-2444 9151

NEW PATIENT REGISTRATION FORM

0275/OPD/MRD/2009

(To be filled in English with Black ink in Capital Letters)

If the patient has a Hinduja Hospital (HH) number, please DO NOT fill this form. Please provide this number at the counter or kindly enquire

Date D D M M 2 0 Y Y **HH No.:** (To be filled by Hospital staff)

Name TITLE (Mr./Ms./Dr.etc) LAST (SURNAME) FIRST NAME MIDDLE NAME

Date of Birth D D M M Y Y Y Y **Age:** Years Months Days

Marital Status Married Single Widowed Divorced

Gender Male Female Others

Occupation **Religion:**

Resi. Address

City / Town **Pin / Zip Code:**

State **Country :**

Nationality

Tel. No.(Res.) (STD/ISD Code) **Office :** (STD/ISD Code)

Mobile 1 **Mobile 2 :**

Email-Id

Responsible Person / Kin Details

Relation Father Mother Husband Wife Other

Name TITLE (Mr./Ms./Dr.etc) LAST (SURNAME) FIRST NAME MIDDLE NAME

Contact No.

Emergency Contact No.

Doctor's Details

Doctor's Name

Referring Doctor's Name

Referring Doctor's Contact Number

General Consent

1. I/We agree for the patient to undergo examination, investigation & treatment as decided by the hospital & also to abide by its schedule of charges, rules & regulation. (available at registration counter)
2. I authorize Mr./ Ms. _____ to take decision on my behalf in case of my inability to do so due to associated medical condition.
3. I understand that I have disclosed my clinical history & other relevant information to the healthcare provider team required for the management of my disease.
4. I am fully aware that the medical treatment may be extended beyond the expected period at the discretion of the doctor.
5. I understand my medical record will be destroyed 3 years after my last visit to this hospital.
6. 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.
7. I certify that I read above & understand the contents. I further state that I have been given an opportunity to ask questions which have been answered fully & to my satisfaction.

Signature _____ **Patient:** **Responsible Person:**

HH CONFIDENTIAL: **PTO for:** saaQaarNa sahmaitA સામાન્ય સંમતિ sava-saamaanya saMmait