Patient Registration and Consent

New patient form.

Patient

FULL NAME

EMAIL

PHONE

ADDRESS

DATE OF BIRTH

GENDER

BLOOD GROUP

EMERGENCY CONTACT

THEIR PHONE

Medical history

CURRENT MEDICINES

ALLERGIES

PAST ILLNESSES AND SURGERIES

Payment

How will you pay?

- ○ Self-pay
- ○ Cashless insurance
- ○ Reimbursement insurance
- ○ Corporate / CGHS / ECHS

INSURER / TPA

POLICY NO.

Consent

- ☐ I consent to examination and routine outpatient treatment at this clinic.
- ☐ I agree the clinic may use my details to provide care, bill me or my insurer, and send appointment reminders by SMS, WhatsApp or email.
- ☐ The clinic may also send me health tips and offers. (Optional)

Your data is handled under the Digital Personal Data Protection Act, 2023. You can ask to see, correct or erase it (subject to medical record retention rules) by contacting the clinic.

Patient

SIGNATURE

PRINTED NAME

DATE

Clinic

SIGNATURE

PRINTED NAME

DATE