Accredited by
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PATIENT REGISTRATION FORM

BENGALURU

BANGALORE
BOWEL
CARE

Registration Date :
Consultant's Name :
UHID :

Patient's Name :
Father/Husband's Name :
Address in full :

Telephone :

Age:
Sex

Marital Status

Occupation

Religion

I hereby authorise the above hospital, the physicians and its Medical Staff, the members of its house staff and nursing staff assisted by the employees of the hospitals, to provide such care and administer such diagnostic, radiological and/or therapeutic procedures and treatments as in the judgement of the above physician(s) is deemed necessary or advisable in the above patients care. This includes all routine diagnostic tests and procedures. including diagnostic X-rays, CT scan, MRI, the administration and for injection of pharmaceutical products and medications and withdrawal of blood for laboratory or pathology. "It is likely that students and trainees will participate in care processes". I acknowledge the fact that the hospital has the authority to dispose off the specimens taken for laboratory examination. In addition, I hereby authorise any and all persons caring for me including post graduate medial trainees during the hospitalisation.

I here by authorise all medical nursing and paramedical staff of Apollo Hospital, to conduct all necessary investigations including HIV testing and administer the necessary treatment, including all surgical operations under anaesthesia, as and when required or deemed necessary for the diagnosis and treatment.

My family and I have read the rules & regulations of the Apollo Hospitals given to us and agree to abide by them. All cash jewellery and other valuables have been removed by me to a place of safety. I/We do not hold the hospital authorities responsible for any kind of loss sustained by me or my family.

TO BE FILLED BY THE LEGAL HEIR / GUARDIAN

I undertake the full responsibility of clearing all dues payable to the hospital authorities during the patient's stay here in case of any eventuality occurring to the patient I promise to arrange the full payment of dues either by me or by the legal heirs of the patient immediately. In the event of my failure to clear off all the dues to the Hospital, at the time of patient's discharge, it shall be open to the hospital authorities to take civil and criminal action against me.

AUTHORISATION FOR RELEASE OF INFORMATION

I hereby authorise the co-ordinator, Department of health information Management to release any document from my Medical Record for the purpose of research, claim or settlements to any person or agency or company permitted under law. I agree to have my medical information from the hospital sent to Apollo Prism Account. Apollo Prism is an electronic Personal Health Record, that lets the hospital share your health information securely with you. The information provided here for registration to this service is accurate to the best of my knowledge. I understand that I am responsible for the security of my passwords and for any use of my Apollo Prism Account. Any content within Apollo Prism is for informational purposes only, and is not intended to be a substitute for professional medical advice.

I shall not hold the authorities of APOLLO HOSPITALS, BENGALURU liable for any legal cost or consequences arising from the release of said information.

I/We have signed the above on my/our own free will after understanding fully the contents and the explanations given to me/us by the Hospital authorities including the doctors.

Signature of the Patient _____

Signature of Legal Heir / Guardian_____
(relationship with the patient)

Date _____

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RECEIPT

BANGALORE
BOWEL
CARE

Received with thanks from :

The sum of Rs.

(Rupees

at Registration fee

Reg. No.

Cashier