DSEH / OPD / 01

#191/1, Link Road, 2nd Cross,
Malleshwaram, Bangalore - 560 003
Phone : 080-2356 2211, 080-2356 2299
E-mail : info@drsolankieyehospital.com
Website : www.drsolankieyehospital.com

Patient's Information Form (For Registration)

PATIENT'S NAME:	MRD No.:
OCCUPATION :	DATE :
E-MAIL ID :	AGE :
MARITAL STATUS : YES/ NO	SEX : M/F
HOUSE ADDRESS : PHONE/MOBILE NO.	OFFICE ADDRESS: PHONE/MOBILE NO.
FATHER'S/ HUSBAND'S/GUARDIAN'S NAME:	
PRESENTING COMPLAINT:	LANGUAGE KNOWN :
	REFERRED BY :
HAVE YOU BEEN A PATIENT AT OUR HOSPITAL BEFORE : **YES / NO**	HEALTH INSURANCE: YES / NO
	THROUGH EMPLOYEE YES / NO

KINDLY NOTE: THE NORMAL EYE EXAMINATION MAY TAKE 1½ HOUR. IN CASE OF FURTHER INVESTIGATION EXTRA TIME MAY BE TAKEN

FORM OF CONSENT

I,...unreservedly and in full knowledge give my complete consent for the performance of any diagnostic examination, investigation, procedure as may be deemed advisable.

Date...........................

In case of Minor ....

Signature of Patient