Sir H. N.
Reliance
Foundation Hospital
RESPECT FOR LIFE

Organization Accredited
by Joint Commission International

REGISTRATION FORM

Please fill out all fields marked by asterisk (*)

Last Name*

First Name*

Middle Name

Date of Birth* Sex Female Male

Nationality Religion

Identification Mark 1

Marital Status M S D Blood Group

Occupation Business Owner Govt Employee Housewife Professional

Retired Salaried Student Not Applicable

Annual Income Range Less than 50000 50000-100000 100000- 300000

300000- 500000 500000- 1000000 More than 1000000

Address*

City*

Pincode* District

Country

Mobile Number* Landline Number

Email
(Optional)

Company Name

Company Address

Language

ID Document Type Driving Licence Aadhar Card Pan Card Other Govt Photo ID

ID Document No

To Receive Promotional Offers Tick Here SMS Email

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NEXT OF KIN (EMERGENCY CONTACT PERSON)

Relationship

Last Name*

First Name*

Middle Name

Address Same as above ☐ (If Not Please Write below)

City

Pincode District

Country

Mobile Number* Landline Number

Email

OUT PATIENT AND EXECUTIVE HEALTH CHECK GENERAL CONSENT

I, the undersigned hereby give my consent and authorize Sir H. N. Reliance Foundation Hospital and Research Centre and all its treatment providers engaged through the various clinical departments, doctors, nurses and other care-givers to provide routine medical care and treatment, such as physical exams, diagnostic procedures, treatment of illnesses and injuries, and/or make necessary referrals., in conducting my Health Checkup.

I also acknowledge that other types of healthcare professionals such as Physiotherapists, Technicians, Dieticians, other paramedical staff including observers/intern/students may take part in the provision of care under the supervision /direction of physicians.

I understand and acknowledge that this general consent is taken at the time of initial registration and is valid for subsequent visits to the hospital for similar purpose or otherwise.

☐ Patient/ ☐ Legally Authorized Representative Sign	Date: DD - MM - YYYY Time: HH - MM
Name of Legally Authorised Representative	Relationship with Patient
Interpreter Name	Interpreter's Sign