PATIENT CONSENT FORM

INGALE HOSPITAL
PCMC Registration No.: 81
Doctor: Dr. Nihar Ingale
MMC Registration No.: 2005/01/0366

A. Patient Details

Patient Name: _____

Age: _____ Gender: _____

Mobile Number: _____

Email: _____

Address: _____

Date: _____

B. Consent for Medical Consultation

I confirm that the information provided by me regarding my medical history, symptoms, and health concerns is accurate to the best of my knowledge.

I understand that the doctor may recommend clinical examination, investigations, or further medical evaluation depending on my condition.

I understand that medical advice and treatment decisions are based on individual clinical assessment.

C. Consent for Medical Information

I understand that relevant personal and medical information may be collected and maintained for consultation, treatment, hospital administration and applicable legal requirements.

I understand that my information will be handled with appropriate confidentiality.

D. Consent for Communication

I agree to be contacted regarding my appointment and consultation-related information through the contact details provided by me.

Preferred communication:

[ ] Phone

[ ] SMS

[ ] Email

[ ] WhatsApp

This consent does not include unrelated promotional communications.

E. Patient Declaration

I confirm that:

- I have read and understood the information provided in this form.
- I have been given an opportunity to ask questions.
- I voluntarily provide the above information.
- I understand that this form does not replace separate informed consent for surgery, anesthesia, or other medical procedures.

F. Signature

Patient Name: _____

Patient Signature: _____

Date: _____

Parent / Guardian Name (if applicable):

_____

Relationship: _____

Signature: _____

Hospital Use

Doctor/Authorised Representative: _____

Signature: _____

Date: _____

Note: Any proposed surgery, invasive procedure, or anesthesia requires a separate informed consent process explaining its purpose, expected benefits, material risks and alternatives.