EYE&RETINA SURGEONS

EYE&AESTHETIC SURGEONS EYE&CORNEA SURGEONS EYE&GLAUCOMA SURGEONS

Patient Registration Form

Salutation: Dr/Mr/Mrs/Ms/Mst/Miss/Specify: _____

Full Name: (Please underline Family Name) _____

(as per NRIC / FIN / Passport)

NRIC / FIN / Passport No: _____

Nationality: _____

Gender: Male / Female

Date of Birth: ____ / ____ / ____ (DD/MM/YY)

Address: _____

_____

Telephones: _____

Mobile: Home: Office:

E-mail address: _____

Preferred Language(s): _____

Drug Allergies: _____

Source of referral:

☐ Doctor (pls specify): _____

☐ Family/Friend ☐ Internet ☐ Others (pls specify): _____

The information provided is true and correct to the best of my knowledge.

I am aware and agree to the following:

1. In accordance with the Personal Data Protection Act 2012, we have implemented safeguards to protect your personal data that is collected, used and disclosed by our clinic. Please refer to **www.ers.clinic/Privacy-Policy.html** for more information.
2. Medical data concerning your treatment and video recordings of your surgery (if any) may be used in clinical studies and presentations at medical conferences. Your identity will never be disclosed.
3. This clinic has 24 hour video surveillance for the safety and security of patients, visitors and staff.

Signature of Patient* : Date:

**If this form was completed on behalf of the patient, please provide the following information:*

Name of person completing form: _____

Signature of person completing form: _____

Revised: September2018