



Registration Form

UHID : 43276543687 Date of Birth :
Name : Nationality :
ACN : Preferred Language :
Gender/Age : / Employment Status :

Additional Info

Address : Name : Address :
Postal code : City : Postal Code : City :
Country : Mobile No. : State : Country :
Email : Mobile No. Email

Next of Kin/Emergency Contact

Special Assistance : ☐ Yes ☐ No

Referral : ☐ Walk In ☐ Newspaper ☐ Social Media ☐ Friend/Family ☐ Corporate Tie-up ☐ Website ☐
Source : Neighbourhood ☐ Doctor Referral ☐ Others

Payment Type : Self Policy/Mem.ID : Some ID No Eligibility : Self Paying
Sponsor Type : Sponsor type Reg User : MahaLakshmi R Time of Reg : 06/11/2023 11:49:15 AM

1. Are you suffering from fever, cough or any respiratory symptoms in last one week? : ☐ Yes ☐ No
2. Do you have any history of fever and rashes in the past two weeks? : ☐ Yes ☐ No
3. have you travelled out of country in last 1 month? if yes mention the name of the country? : ☐ Yes ☐ No
3. Has there been any disease outbreak(like Swine flu, Ebola, Covid-19) in your country? : ☐ Yes ☐ No
3. Are you a healthcare worker (Nurse, Physician, allied health service personnel, Laboratory worker)? : ☐ Yes ☐ No
6. Have you been exposed to any of the following disease in last 1 month? : ☐ Yes ☐ No
- : ☐ Chicken Pox ☐ Measles ☐ Mumps ☐ Rubella
7. Currently are you having diarrhea symptoms? : ☐ Yes ☐ No
8. Have you ever been told/referred by a health care provider that you have a active TB? : ☐ Yes ☐ No

Disclaimer

I hereby consent/authorize the hospital physician & personnel to perform physical examination, and to give treatment. I permit all persons caring for me at this facility to treat me in a ways they judge are beneficial to me. I understand that this care may include tests, examinations, x-rays and collection of blood or other bodily fluids.