

FORM DESIGN

Admin home

THANAL.com					
HOME	HEALTH ISSUES	SCIENTIFIC INFO	LIVING WITH PARALYSIS	HOME NURSE	LOGOUT

Appointment form

APPOINTMENT FORM	
Name :	<input type="text"/>
Age :	<input type="text"/>
Gender :	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Others
City. :	<input type="text"/>
Doctor Name :	<input type="text"/>
Date :	<input type="text"/>
Mobile No :	<input type="text"/>

Doctor registration

REGISTRATION FORM	
Name :	<input type="text"/>
Mobile No :	<input type="text"/>
House Name :	<input type="text"/>
City :	<input type="text"/>
District Name :	<input type="text"/>
Gender :	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Others
Hospital Name :	<input type="text"/>
Specialization :	<input type="text"/>
Qualification :	<input type="text"/>
Upload Certificate :	<input type="button" value="Browse Here"/>
Experience :	<input type="text"/>
Username :	<input type="text"/>
Password :	<input type="password"/>
<input type="button" value="Register"/>	

Hospital home

THANAL.com					
HOME	HOSPITAL INFO	DOCTOR APPOINTMENTS	ADD DOCTORS	UPDATE DOCTOR DETAILS	LOGOUT

Login

LOGIN	
User Name :	<input type="text"/>
Password :	<input type="password"/>
<input type="button" value="Login"/>	
New Register?	

Home nurse home

THANAL.com			
HOME	REQUESTED PATIENTS	EDIT PROFILE	LOGOUT

Nurse registration

REGISTRATION FORM

Name	:	<input type="text"/>
Mobile No	:	<input type="text"/>
House Name	:	<input type="text"/>
City	:	<input type="text"/>
Pin Code	:	<input type="text"/>
Gender	:	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Others
email	:	<input type="text"/>
DOB	:	<input type="text"/>
Upload Certificate	:	<input type="button" value="Browse Here"/>
Username	:	<input type="text"/>
Password	:	<input type="text"/>
<input type="button" value="Register"/>		

Patient home

THANAL.com						
HOME	HEALTH ISSUES	SCIENTIFIC INFO	LIVING WITH PARALYSIS	DOCTOR APPOINTMENT	REGISTERED NURSE	LOGOUT

Patient log

PATIENT LOG	
Name :	<input type="text"/>
Age :	<input type="text"/>
Gender :	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Others
Medicine :	<input type="text"/>
Time :	<input type="text"/>
Doctor Name :	<input type="text"/>

Patient registration

REGISTRATION FORM	
Name :	<input type="text"/>
Mobile No :	<input type="text"/>
House Name :	<input type="text"/>
City :	<input type="text"/>
Age :	<input type="text"/>
Gender :	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Others
Category :	<input type="text"/>
Username :	<input type="text"/>
Password :	<input type="text"/>
Register	