

FOR OFFICE USE ONLY (All dates in DD/MM/YYYY format)

MR / / IP / / BED: WARD:

ADMISSION DATE: TIME: AM / PM. Under DR.

PROCEDURE DATE: TIME: AM / PM. OT Floor: OT No.

Surgeon 1 DR. Surgeon 2 DR. Duration: Hrs.

Anaesthetist DR. OT Time: From AM / PM. To AM / PM.

Special Instructions:

EDD (For Obs. Cases) Diagnosis

Estimate: Rs. Advance: Rs. Total Bill: Rs.

Total Paid: Rs. Total Due: Discharged on:

PAYMENT BY: ☐ PATIENT / PARTY ☐ OTHER (Name)

INFORMED: ☐ MATRON ☐ HOSPITAL ADMINISTRATOR ☐ HOUSEKEEPING ☐ F & B

TO BE FILLED IN BY THE PATIENT / AUTHORISED PARTY

(PLEASE FILL IN BOLD LETTERS - All dates in DD/MM/YYYY format)

Have you registered as an Inpatient / Outpatient before? ☐ YES ☐ NO

FIRST NAME: MIDDLE NAME: LAST NAME:

AGE: Years Date of Birth: Sex: ☐ MALE

ADDRESS: ☐ FEMALE

Police Station: Pin Code: Residence Phone No.:

ADDRESS: (Permanent)

Police Station: Pin Code: Residence Phone No.:

Occupation: Name & Address of Employer:

Office Phone No.:

Email ID: Mobile No.: Fax No.:

Religion: Nationality: Passport No. (Where applicable)

Date & Place of Issue: Date of Expiry: Kolkata Phone No.:

Name of Father / Husband: Occupation:

Other Next of Kin / 1. Name: Relation: Contact No.:

Emergency Contacts:

FEES PAYABLE BY ☐ SELF* ☐ COMPANY / CORPORATE (Name)

(Subject to submission of Letter of Guarantee from Company)

☐ CASHLESS THROUGH TPA (Name) CARD NO.

(Subject to Valid Authorisation and Self Payment of Balance / Non-reimbursables)

REFERRED BY: ☐ FAMILY DOCTOR ☐ COMPANY DOCTOR ☐ OTHER DR. (Name)

ROOM REQUESTED FOR: ☐ SINGLE ☐ DOUBLE ☐ OTHERS. DIET: ☐ Veg. ☐ Non-veg.

Please note that allocation will depend on availability. Any request for change of room must be submitted in writing to the ward-in-charge or admission office. Transfers be made as per medical priorities - In case of disputes, the decision of the Medical Director will be treated as final.)