Smart Isntitute of Rehabilitation Medicine

Tell No:

Email address:

Date:

Registration Form

Name of Patient:

CNIC No.															
MR No.				Date of Birth:				Gender:							
Category: Resident ☐ Non-Resident ☐ Employee ☐															
Permanent Address:															
Phone#				Cell#				Email:							
AGE:								Blood Group:							
Reffering Doctor Name:								Contact No.							
Address:															
Emergency Contact															
Name:					Relation:				Contact#						