International Healthcare Program

7th - 10th September, 2017

Kenya

Patient Registration Form

Hospital / Institution Name.....Date.....

Title: Mr. ☐ Ms. ☐ Mrs. ☐

Patient Full Name*.....

Are you Medically Insured* ☐ Yes ☐ No Gender* ☐ Male ☐ Female

Marital Status* ☐ Married ☐ Single

Date of Birth (DD/MM/YYYY).....

Age.....

Occupation*.....

Permanent Address & Pincode*.....

.....

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Contact Telephone*.....Mobile*.....

EmailID*.....

**** Mandatory for Registration***

To visit which Department

☐ Cardiology ☐ Neurology ☐ Oncology ☐ Gynaecology ☐ Bariatrics

☐ Paediatric Surgery

Reports Enclosed (if any)

☐ CT Scan ☐ X-Ray ☐ Blood ☐ MRI

Others (please specify).....

Referred by Doctor*.....

Whether the medical history of the patient by referring hospital / doctor produced* ☐ Yes ☐ No

Contact:
Hasanain Ahmed Molu
Globetrotters Mombasa
Phone: +254 731 978607 / +254 722 315172
Email: hashzain@theglobetrotters.in

Signature of patient

Program Manager:
CIMGlobal
Phone: +91 80 2608 0700
Email: connect@ihtc.in

www.ihtc.in