ADMISSION FORM

General

Name:

Age: Religion: Marital status:

Education:

Addresses (a) Permanent: (b) Present:

Details of family Members

Name Relationship

Address

Contacts: Tel Mobile e-Mail

Next of Kin

Name ______________________________ Relationship ____________

Address ____

____

____

Contacts Tel ___________ Mobile __________ e-Mail ____________

Local Contact (for emergencies)

Name ____________________________ Relationship ______________

Address ____

____

____

Contacts Tel ___________ Mobile __________ e-Mail ____________

Brief professional background ______________________________

____

____

Interests and Hobbies ______________________________________

____

Sickness

In the event of serious sickness necessitating hospitalisation, please specify preferred hospital, specialists and mode of payment of expenses.

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Will

Have you executed your will? ________________________

Location (optional) ________________________

Last Rites

In the event of your death, please specify who is to be informed and give details of the conduct of desired last rites.

____

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Optional

Financial Status and source of funds________________________

____

____

____

Bank ________________________ AC No ________________

Address ________________________

____

____

Locker location ________________________

Legal disputes, if any ____

____

Income Tax disputes, if any ____

____

____

Please furnish photocopies of your passport, PAN Card and Voter ID Card   Voter I Card photocopy

Disclaimer

Signatures ____________________

____

Resident

Sponsor ________________

Name ________________

Address ________________

____

Tel ____________________

e-Mail ID ______________

Witness ________________

Name ________________

Address ________________

____

Tel ____________________

e-Mail ID ______________

Medical information

Name

Age Sex Male Female

Are you suffering from

1. Heart problem
2. Diabetes
3. Blood pressure(high or low)
4. Any other chronic illness requiring prolonged treatment
5. Any communicable disease

6. Visual /hearing problem ______________________________

____

____

7. History of past illnesses which required hospitalization/ surgery (pls give details of your age at that time)

____

____

____

____

8. Your own doctor

Name ____

Contact information ___________________________________

General Information

1. Any allergies____

2. Addictions

- Smoking ☐ Yes ☐ No
- Alcohol ☐ Yes ☐ No
- Drugs ☐ Yes ☐ No

3. Any disability requiring assistance ______________________

4. Any diet restrictions ____________________________________

____

____

5. Anything else you want us to know about you___________

____

____

Signature of resident ____

Signature of registered medical practitioner _________________

Place___________________________ date ____/____/__________