AYUR SHIELD
AYURVEDA FOR IMMUNITY

AYURSHIELD IMMUNITY CLINICS: PATIENT REGISTRATION FORM

(PLEASE FILL ALL THE FIELDS IN CAPITAL LETTERS)

MRD. NUMBER: _____ **DATE OF REGISTRATION**

Patient's Name						
Age		**DOB**		**Gender**		**Marital Status:** (OPTIONAL)
Religion				**Mob No.**		
Present Address:				**Permanent Address:**		
E- Mail id						
District		**State**		**Nationality**		
Occupation						
Father/Spouse's Name:						
EMERGENCY CONTACT DETAILS						
Name of the Person		**Relationship**		**Contact No.**		
Medical Insurance Provider & Policy Number:						
Questionnaire: If yes to any question, please provide the details with timeline:						
Have you been to any Covid19 affected countries**? Yes/No** – **Test Done: Yes / No**						
Have you been to any Hot Spots as declared by State or Central governments? **Yes/No**						
Have you been in close contact with any Covid19 suspects? **Yes/No** – **Primary / Secondary**						
Have you or anyone in your close circle advised to be in Quarantine by authorities? **Yes/No**						
Whether you were suffering from fever/cough/sore throat/chest congestion in last 30 days? **Yes/No**						

Declaration: I hereby declare that **the details furnished above are true** and **correct** to the best of my knowledge and belief. I authorize the release of medical information necessary to process the bills with my Insurance Company in case of claims. I also acknowledge that the details of illness without person identifiable data may be used for statistical analysis as part of research or for the purpose of Treatment Protocol development/evaluation.

Name: **Signature/Thumb impression:**

Date: