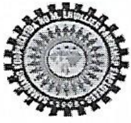

SAMAHANG KOOPERATIBA NG MLHUILLIER PAWNSHOP'S EMPLOYEES
11th FLOOR HEART TOWER CONDOMINIUM 108 VALERO STREET SALCEDO VILL. MAKATI CITY
TELEFAX : (02) 843-2485 TELEPHONE: (02) 310-0056

HOSPITALIZATION CLAIM FORM

PART III: TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Name of Patient : ______________________ Birthdate ____________ Age : ________

Was patient hospitalized? [ ] YES [ ] NO Hospitalized at : ______________________

Is this hospital/clinic registered with the Bureau of Medical Services? [ ] YES [ ] NO If not,does it have a permit to operate as Hospital/Clinic & to admit in patients [ ] YES [ ] NO

Registered / Permit No. __________ Date Isued/Issued By: ______________________

Date of Confinement : Admitted on : ______________________ at ______ am/pm
Discharge on : ______________________ at ______ am/pm

COMPLETE AND FINAL DIAGNOSIS (If injured,give dates and place of accident)

____
____
____

SHORT HISTORY OF ILLNESS OR DISABILITY :

____
____
____

Did disability or illness arise out of and in the course of the patient's employment ? ___ YES _____ NO

If so explain briefly: ____
____

Is disability due to Pregnancy? [ ] YES [ ] NO If yes,give approximate date of first day of last menstruation : ______________________

COMPLETE IF X-RAY OR LABORATORY SERVICES WERE PERFORMED (If with previous,please indicate also)

Type of Examination ______________________ Findings ______________________

Date ______________ Where Performed ______________ Fee Charged ______________

Previous consultation/treatment as out/in-patient prior to this confinement

PLACE	DATES	DIAGNOSIS
Office		
Home		
Hospital		

TO BE COMPLETED IF SURGERY WAS PERFORMED: Nature of Surgical Operation/Obstetrical procedure performed

____
____
____

Date Performed : ______________ Where performed : ______________

If performed in Hospital check whether as : [ ] In Patient Out Patient

Name of Surgeon : ______________________ Fees Charged : ______________

Name of Anesthesiologist : ______________________ Fees Charged : ______________

OTHER DOCTORS WHO ATTENDED TO YOUR PATIENT :

NAME	SPECIALTY	PROCEDURES	DATE	FEES
1				
2				
3				

The patient has been continously disabled (unable to work) FROM ______________ TO ______________

When should your patient be able to work ? ______________________

REMARKS : ____
____

I HEREBY CERTIFY that the foregoing answers have been taken from the medical / hospital records of the above Named patient. They are full complete,correct and true.

I am a graduate of ______________________ in the year __________

______________________ ______________________
NAME OF ATTENDING PHYSICIAN (please print) Signature of Attending Physician

Address: ______________________ Date Signed : ______________

Telephone No. ______________________ License No. ______________