Your hospital's name

Address · Phone

PATIENT ADMISSION FORM

UHID _____ IP number _____

Date of admission _____ Time of admission _____

1. PATIENT

Full name _____ Father's or spouse's name _____

Age _____ Date of birth _____

Sex _____ Mobile number _____

Address, with PIN code _____

Photo ID type _____ Photo ID number _____

2. ATTENDANT AND EMERGENCY CONTACT

Attendant's name _____ Relation to the patient _____

Attendant's mobile _____ Emergency contact, if different _____

In an emergency: who brought the patient, and their phone number _____

3. ADMISSION

Admission type ☐ Elective (planned) ☐ Emergency ☐ Day care ☐ Maternity ☐ Observation

Came from ☐ OPD ☐ Emergency ☐ Referral ☐ Walk-in

Referred by: doctor and hospital _____

Medico-legal case (MLC) ☐ Yes ☐ No

Consultant _____ Department _____

Other consultants, if any _____

Reason for admission _____

Planned surgery or procedure _____

Date of surgery or procedure _____ Expected stay _____

4. WARD AND BED

Ward, room and bed _____

Room category _____ Rent per day _____

5. PAYMENT AND INSURANCE

Payment ☐ Self-paying ☐ Cashless insurance ☐ Reimbursement ☐ Corporate (the employer pays)

Insurer _____ TPA _____

Policy number _____ Policy valid from and to _____

Health card or member ID _____ Policyholder and relation _____

For a corporate patient: company name and employee ID _____

6. ADVANCE

Paid by ☐ Cash ☐ Card ☐ UPI ☐ Bank transfer

Amount _____ Reference number _____

Receipt number _____ Receipt date _____

Who will pay the bill _____ Relation to the patient _____

Your hospital's name

Address · Phone

PATIENT ADMISSION FORM

Patient's name _____ UHID _____

IP number _____ Date of admission _____

7. CONSENT AND SIGNATURES

I agree to be admitted to this hospital under the consultant named above. I agree to the tests and treatment my doctors advise. The room category, its rent and the advance have been explained to me. I will follow the hospital's rules. I will pay the bill, including any part that my insurer does not pay. The details I have given on this form are true. I allow the hospital to share my medical records with my insurer and TPA for my claim.

Patient's signature *With date and time*

_____

If the patient cannot sign *Who signs, their relation to the patient, and why*

_____

Witness *Staff name and signature*

_____

Received on the ward *Nurse's name and time*

_____

SAMPLE: A MADE-UP PATIENT

City Hospital

Main Road · Phone 00000 00000

PATIENT ADMISSION FORM

UHID **PAT-00421**

IP number **IPD-2026-00417**

Date of admission **27-10-2026**

Time of admission **11:23 am**

1. PATIENT

Full name **Lakshmi Devi**

Father's or spouse's name **Wife of K. Kumar**

Age **54**

Date of birth **14-07-1972**

Sex **Female**

Mobile number **00000 00000**

Address, with PIN code **Door no. 00, Main Road, PIN 000000**

Photo ID type **Voter ID**

Photo ID number **ABC0000000**

2. ATTENDANT AND EMERGENCY CONTACT

Attendant's name **Naveen Kumar**

Relation to the patient **Son**

Attendant's mobile **00000 00000**

Emergency contact, if different **Same as the attendant**

In an emergency: who brought the patient, and their phone number **Not needed**

3. ADMISSION

Admission type ☑ Elective (planned) ☐ Emergency ☐ Day care ☐ Maternity ☐ Observation

Came from ☑ OPD ☐ Emergency ☐ Referral ☐ Walk-in

Referred by: doctor and hospital **Not needed**

Medico-legal case (MLC) ☐ Yes ☑ No

Consultant **Dr. P. Reddy**

Department **General Surgery**

Other consultants, if any **Physician, for her diabetes**

Reason for admission **Gallbladder stones with pain**

Planned surgery or procedure **Laparoscopic cholecystectomy (keyhole removal of the gallbladder)**

Date of surgery or procedure **28-10-2026**

Expected stay **4 days**

4. WARD AND BED

Ward, room and bed **Private room, bed P-204**

Room category **Private (one bed)**

Rent per day **5,000 rupees**

5. PAYMENT AND INSURANCE

Payment ☐ Self-paying ☑ Cashless insurance ☐ Reimbursement ☐ Corporate (the employer pays)

Insurer **Ganga Health**

TPA **Kaveri TPA**

Policy number **0000000000**

Policy valid from and to **01-04-2026 to 31-03-2027**

Health card or member ID **00000000**

Policyholder and relation **Lakshmi Devi, self**

For a corporate patient: company name and employee ID **Not needed**

6. ADVANCE

Paid by ☐ Cash ☐ Card ☑ UPI ☐ Bank transfer

Amount **10,000 rupees**

Reference number **629916370548**

Receipt number **R-0566**

Receipt date **26-10-2026**

Who will pay the bill **Naveen Kumar**

Relation to the patient **Son**

SAMPLE

SAMPLE: A MADE-UP PATIENT

City Hospital

Main Road · Phone 00000 00000

PATIENT ADMISSION FORM

Patient's name **Lakshmi Devi**

UHID **PAT-00421**

IP number **IPD-2026-00417**

Date of admission **27-10-2026**

7. CONSENT AND SIGNATURES

I agree to be admitted to this hospital under the consultant named above. I agree to the tests and treatment my doctors advise. The room category, its rent and the advance have been explained to me. I will follow the hospital's rules. I will pay the bill, including any part that my insurer does not pay. The details I have given on this form are true. I allow the hospital to share my medical records with my insurer and TPA for my claim.

Patient's signature

With date and time

Signed by Lakshmi Devi, 27-10-2026, 11:15 am

If the patient cannot sign

Who signs, their relation to the patient, and why

Not needed

Witness

Staff name and signature

Signed, admission desk staff, 11:15 am

Received on the ward

Nurse's name and time

Anitha, staff nurse, 11:45 am

SAMPLE