

REGISTRATION

Patients Photo

| | |
|-------------------------|--|
| NAME | |
| DATE OF BIRTH/ AGE | |
| WEIGHT / HEIGHT | |
| FATHER NAME | |
| FATHER'S OCCUPATION | |
| MOTHER NAME | |
| MOTHER'S OCCUPATION | |
| ADDRESS | |
| | |
| | |
| CONTACT NUMBER (MOBILE) | |
| | |
| INCOME PER MONTH | |
| SIBLINGS | |

| | |
|-----------------------------------|--|
| TREATING DOCTOR (Name/Address) | |
| | |
| | |
| EYE REPORTS(Attach) | |
| | |
| | |
| GENERAL REPORTS (Attach) | |
| | |
| | |
| | |
| MEDICATIONS (Attach) | |
| | |
| | |
| | |
| | |
| DIET | |
| | |
| | |
| REMARKS | |

SIGNATURE OF PARENT / GUARDIAN