ApolloMunich
HEALTH INSURANCE

Apollo Munich Health Insurance Co. Ltd.
Off. 10th Floor, Tower-B, Building No. 10
DLF Cyber City, DLF City Phase -II, Gurgaon, Haryana-122002

O) Medical Report (to be filled by Treating Doctor)

Patient's Name____

Date of Birth (DDMMYYYY)____________________________ Gender: Male ☐ / Female ☐

Patient's Address____

____

____

Date and Time of first consultation____

Dates of treatment: Start______________________ End______________________

Date of admission______________________ Date of discharge______________________

Nature of complaints____

____

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Diagnosis____

Treatment given____

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History of presented complaints____

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Is the present condition due to pregnancy? Yes ☐ No ☐ If yes, provide details______________________

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Is the present condition due to any pre-existing condition? Yes ☐ No ☐ If yes, provide details______________________

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Please provide history of any disease, accident or hospitalisation with details and duration______________________

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Date and Time of the accident____

Are the injuries suffered solely due to the accident? Yes ☐ No ☐ If no, provide details______________________

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Was the patient under influence of alcohol/drugs at the time of the accident? Yes ☐ No ☐

Is the injured person totally disabled from each and every occupation? Yes ☐ No ☐

Is the injured person partially disabled from occupation? Yes ☐ No ☐ If yes, please provide the percentage of disability

____

Prognosis of the ailment/injury____

____

In your opinion when will the injured person be able to resume duties?______________________

I hereby to the best of my knowledge and belief, warrant the truth of the above details in every respect.

Place______________________ Date______________________ Reg.No.______________________

Name, address and stamp of Doctor____

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Signature____

AMHI/ET/0310

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