

PHILIPPINE HEART CENTER
East Avenue, Quezon City

SOCIAL SERVICES DIVISION

DOH MAIP PATIENTS' INFORMATION

DATE

/ / NEW / / OLD

IDENTIFYING INFORMATIONS:

Name of Patient: _____

(Surname) (First Name) (Middle Name)

Birth Date: _____ Age: _____ Status _____ Religion _____

Address: _____

Educational Attainment: _____ Patient/s Monthly Income/Pension _____

Total Number of Household _____ Combined Monthly Income: _____

Contact Person /Contact Number: _____

Diagnosis: _____ Hospital: _____

Assistance Needed: / / Gamot / / Laboratory / / Procedure / / Rehabilitation / / Hospital Bill

Amount of DOHMAP w/ GL _____

(INFORMANT) Relation to Patient:
Signature over printed name

HILDA Z. ABELLAR, RSW
DOH-MAP In-Charge
Social Welfare Officer

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