Part B (to be completed by the attending physician)

1. Patient's Name: ______________________
2. History of illness and concurrent conditions requiring hospitalization: ______________________

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3. Final Diagnosis: ______________________
4. Date symptoms of present illness first appeared or accident occurred: ______________________
5. Date patient first consulted you for this condition or symptoms: ______________________
6. Results of any X-Ray, ECG, other laboratory tests: ______________________
7. Any other illness or other impairments to your knowledge? ☐ YES ☐ NO **If YES, please give full details:**

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8. Was any surgical operation performed? ☐ YES ☐ NO **If YES, please give full details:**

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9. Is the patient taking maintenance medications? ______________ What medicines? ______________

______________ Since when? ______________
10. Name of doctor who prescribed maintenance medication: ______________________
11. If hospitalization was due to accident, how did the accident occur? ______________________

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12. Was the patient under the influence of alcohol or drugs on the onset of illness or at the time of the accident?

☐ YES ☐ NO **If YES, please give full details:** ______________________
13. Have you treated or medically advised the Patient in the past? ☐YES ☐NO **If YES, please supply the nature of illness or injury and date of consultation / confinement, diagnosis, prognosis and treatment/s given:** ______________________

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14. Has the Patient consulted any other physician? ☐YES ☐NO **If YES, please supply the name of the physician, illness or injury and dates of consultation / confinement, diagnosis, prognosis and treatment/s given:** ______________________

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15. Dates of Hospital Confinement: From: ______________ To: ______________
16. Name of Hospital: ______________________
17. Your Full Name: ______________________
18. Address of Hospital: ______________ Tel No.: ______________

I hereby depose and say that the foregoing answers are true and correct to the best of my knowledge including any accompanying statements and there are no material facts in the case which are not disclosed. I hereby authorize the Medical Records of the Hospital mentioned above to furnish Paramount Life & General Insurance Corporation or its authorized representatives any and all information with respect to the sickness or injury, medical history, consultation, treatment and copies of all Hospital medical/clinical records of the aforementioned patient. A photocopy of this authorization shall be considered as effective and valid as the original.

Your Signature: ______________________ Date: ______________

Send this form along with other requirements mentioned to:

11th Floor Sage House, 110 V. A. Rufino Street, Legaspi Village, Makati City 1229, Philippines
Telefax Number: 772-9264
Mobile Numbers: 0939 825 0287 • 0905 243 6166 • 0922 889 4841