

Hospital Patient Visitor Registration Form

Please complete all fields below. This form is for visitor registration and record-keeping purposes.

Visitor Information

Visitor's Full Name:

Contact Phone Number:

Residential Address:

Relationship to Patient:

Patient Information

Patient's Full Name:

Ward / Room Number:

Visit Details

Date of Visit (DD/MM/YYYY):

Time In (AM/PM):

Time Out (AM/PM):

Health Declaration

Are you currently experiencing any fever, cough, or flu-like symptoms? (Enter Yes or No):

Verification & Signatures

Visitor Signature (Write Name to Sign):

Hospital Staff Verification Initials: