



# PIONEER DIAGNOSTIC CENTER PLC

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## X-RAY REGISTRATION FORM (PATIENT DATA)

Name: .....

Age: ..... Sex: .....

Xray of .....

PatientHistory.....  
.....  
.....  
.....

Appointment Date & Time.....

Signature of Patient.....

Telephone No .....

የታካሚውን መጠየቂያ ፎርም የሞላችው/ው ባለሙያ ስም Name of the Nurse that filled the patient form	
_____	
ፊርማ _____ Signature	ቀን _____ Date

ፓዮኒርን ስለመረጡ አናመሰግናለን!  
Thank you for Choosing Pioneer!



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