# Hospital Online Registration Form

## Patient Information

First Name*

Last Name*

Date of Birth*

Gender*

Select...

Contact Number*

Email Address*

Home Address*

Emergency Contact Name*

Emergency Contact Phone*

Health Insurance Provider

Policy Number

Reason for Visit*

## Consent

☐ **I consent to the collection, use, and disclosure of my personal health information for medical treatment and hospital administration purposes in accordance with applicable laws and the hospital's privacy policy. ***

☐

**I confirm that the information provided is accurate and understand that providing false information may affect my treatment.**

☐

I agree to receive appointment reminders and important notifications via email or SMS.

Register