Patient Registration Form

Personal Information

First Name

Last Name

Date of Birth

Gender

--Select--

Marital Status

--Select--

Address

City

State/Province

ZIP/Postal Code

Country

Phone Number

Email Address

Emergency Contact

Contact Name

Relationship

Phone Number

Insurance Information

Insurance Provider

Policy Number

Group Number

Insurance Phone

Medical Information

Primary Care Physician

Current Medical Conditions

Current Medications

Allergies

Previous Surgeries/Hospitalizations

Consent & Privacy Agreement

By signing below, I confirm that the information provided is accurate and complete to the best of my knowledge. I consent to the collection, use, and sharing of my health information for the purposes of treatment, payment, and healthcare operations, as described in the Notice of Privacy Practices. I understand that my records are protected under HIPAA and other relevant regulations and will not be disclosed without my written authorization except as permitted by law.

Signature: _____ **Date:** _____

Submit Registration