#### horizontal line**Patient Registration Form**

##### **Patient Information**

1. **Full Name:**(First Name, Last Name)
2. **Date of Birth:**(DD/MM/YYYY)
3. **Gender:**
   * Male
   * Female
   * Other
4. **Contact Number:**(Include country code)
5. **Email Address:**(Your valid email)

##### **Address Details**

1. **Home Address:**
   * Street Address:
   * City:
   * State/Province:
   * Postal Code:
   * Country:

##### **Medical Details**

1. **Medical History:**(Specify any chronic illnesses)
2. **Allergies:**(Specify, if any)
3. **Current Medications:**(List, if any)
4. **Primary Physician:**(Name and Contact)

##### **Emergency Contact**

1. **Name:**(Full Name)
2. **Relationship to Patient:**(Specify)
3. **Contact Number:**(Include country code)

##### **Insurance Information**

1. **Insurance Provider:**(Name of the insurance)
2. **Policy Number:**(If applicable)

##### **Agreement**

* I hereby declare that the above information is true and correct to the best of my knowledge.
  + I agree to the terms and conditions.

**Signature:**(Upload or sign)

**Date:**(DD/MM/YYYY)