Private Hospital Registration Form

Patient Details

- **Full Name:** _____
- **Date of Birth:** _____
- **Gender:** _____
- **Contact Information:**
  - **Phone:** _____
  - **Email:** _____
- **Address:** _____

Primary Contact in Case of Emergency

- **Name:** _____
- **Relationship:** _____
- **Phone Number:** _____

Insurance Details

- **Provider Name:** _____
- **Policy Number:** _____
- **Coverage Details:** _____

Medical Information

- **Current Medications:**

  _____

- **Known Allergies:**

  _____

- **Significant Medical History:**

  _____

Patient Consent

- **I agree to the terms and conditions of the treatment.**
- **Patient/Guardian Signature: _____**
- **Date: _____**