SERENITY
MEDICAL CENTRE

Patient Registration Form

Please enter your details below:

First and Last Name: _____

Health Card Number: _____

Date of Birth (YYYY-MM-DD): _____

Address: _____

Email: _____

Phone Number: _____

Signature: _____

Date: _____

Select your Doctor (Please check one):

Dr. Kodi Onunkwo []

Dr. Itoro Udo []

Dr. Emmanuel Kanu []

Dr. Michael McNeely []

Dr. Olanrewaju Okusanya []

Dr. Obi Ohakanu []

Dr. Iphie Okete []

Additional Information (Optional):

Emergency Contact Details: _____

Medical History Overview: _____

Insurance Information: _____