West Marin Medical Center
MARIN HEALTHCARE DISTRICT

# Patient Registration Form

| Today's date: | PCP: | Referred By: |
|---|---|---|

**PATIENT INFORMATION**

| Patient's last name: First: Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|

| Social Security Number: | Birth date: / / | Age: | Sex: ❑ M ❑ F |
|---|---|---|---|

| Street Address: | Cell Phone: | Home Phone: |
|---|---|---|

| P.O. Box: | City: | State: | ZIP Code: |
|---|---|---|---|

| Primary Language: | Email: |
|---|---|

| Occupation: | Employer: | Employer address: | Employer phone: |
|---|---|---|---|

| Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Non-Latino ❑ Decline to State | Race: ❑ American Indian/Alaska Native ❑ Asian ❑ African American/Black ❑ Native Hawaiian/Pacific Islander ❑ White ❑ Other ❑ Decline to State |
|---|---|

**INSURANCE INFORMATION**

| Primary Insurance (Carrier & ID #): | Secondary Insurance (Carrier & ID #): |
|---|---|
| Subscriber: | Subscriber's Birth Date: / / |
| Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other | |

**RELEASE OF HEALTH INFORMATION**

| Is okay to leave messages on your phone? ❑ Home ❑ Cell | Is okay to discuss your health information with another person? ❑ Yes ❑ No | Who? |
|---|---|---|

**IN CASE OF EMERGENCY**

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone: ( ) | Work phone: ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I understand that it is my responsibility to notify the clinic of any changes to this information.

*Patient/Guardian Signature* *Date*