Tamalpais Internal Medicine
MARIN HEALTHCARE DISTRICT

Patient Registration Form

Today's date:	Primary Care Physician:	Referred By:

PATIENT INFORMATION

Last Name: First: Middle:	Suffix:	Birth Date: / /	Sex: ❑ M ❑ F

Social Security Number:	Marital Status (circle): Single / Married / Divorced / Separated / Widowed

Mailing Address:	City:	State:	ZIP Code:

Home Phone:	Work Phone:	Cell Phone:

Primary Language:	Email:

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

EMERGENCY CONTACT

Name:	Relationship:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )

INSURANCE INFORMATION

Primary Insurance (Carrier, ID #, Group #):	Secondary Insurance (Carrier, ID #, Group #):
Primary Subscriber Name and Birthdate:	Secondary Subscriber Name and Birth Date:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

RELEASE OF HEALTH INFORMATION

Is it okay to leave messages on your phone? ❑ Yes ❑ No	Is it okay to discuss your health information with another person? ❑ Yes ❑ No	If yes, who?

ACKNOWLEDGEMENT

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

Patient/Guardian Signature *Date*