PREVENTIVE MEDICAL CENTER OF MARIN, INC

Date of your first APPOINTMENT_____**TIME:**_____

Your appointment is scheduled with:_____

PATIENT INFORMATION

(Please complete this entire two-page form and BRING IT WITH YOU)

Patient Name_____ **Home Phone:**_____
Cell Phone:_____
Work Phone:_____

Parent or Guardian (if patient is a minor**)**_____

Sex: M_____ **F**_____

Address:_____

City_____ **State:**_____ **Zip:**_____

Date of Birth_____ e-mail address_____

Current HEALTH INSURANCE Carrier_____

Policy Holder (Insured's Name)_____**ID#**_____

Date of Birth_____ **Group #**_____

Relationship to Insured : (Self) (Spouse) (Child)
(*Circle One*)

Employer's Name_____

Employer's Address_____**Phone:**_____

Spouse's Name_____

Spouse's Employer/Address_____

Who is your current health practitioner or primary care provider?_____

Are you seeing another practitioner at PMCM? If so, Who?_____

Who referred you to PMCM? Name_____

Nearest Relative/Friend/Emergency Name_____

Address and Telephone:_____

**********************PAYMENT IS DUE AT THE TIME OF SERVICE*********************

PMCM, Inc. Patient Registration Form (Continued)

In the undersigned, am financially responsible for all services provided to me at PMCM, and hereby agree that in the event of the default in the payment of any amount due, and if the account should be placed in the hands of an agency or attorney for collections or legal action, I agree to pay additional charges equal to cost of collections. These additional charges may also include agency and attorney fees as well as court costs incurred and permitted by the laws governing these transactions.

Patient Signature _____ Date _____

Parent/Guardian Signature (for minor patient)
_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all medical benefits to which I am entitled, from my insurance or any other health plan, to:

PREVENTIVE MEDICAL CENTER OF MARIN, INC.

25 Mitchell Blvd. #8, San Rafael, CA 94903

Tel: 415-472-2343 Fax: 415-472-7636

www.elsonhaas.com

Tax ID# 68-0295333

Signature: _____ Date _____

Name (Printed) _____