

**PREVENTIVE MEDICAL CENTER OF MARIN**  
PATIENT REGISTRATION FORM

Date of your first APPOINTMENT: \_\_\_\_\_ TIME: \_\_\_\_\_

Your appointment is scheduled with: \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name \_\_\_\_\_

Parent or Guardian (if patient is a minor) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Tel \_\_\_\_\_ Work Tel \_\_\_\_\_

Fax \_\_\_\_\_ Email address \_\_\_\_\_

Would you like to receive our emails? Yes \_\_\_\_\_ No \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Marital Status \_\_\_\_\_ Driver's License # \_\_\_\_\_

Current HEALTH INSURANCE Carrier \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Employer's Name \_\_\_\_\_ How long? \_\_\_\_\_

Employer's Address \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Work Tel \_\_\_\_\_

Spouse's Employer/Address \_\_\_\_\_

Who is your current health practitioner or primary provider? \_\_\_\_\_

Are you seeing another practitioner at PMCM? If so, who? \_\_\_\_\_

Who referred you to PMCM? (Name) \_\_\_\_\_

Address and Telephone \_\_\_\_\_

Nearest Relative/Friend/Emergency Name & Tel \_\_\_\_\_

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

**PREVENTIVE MEDICAL CENTER OF MARIN**  
PATIENT REGISTRATION FORM

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)

\_\_\_\_\_  
Date

**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.pmcmarin.com

Tax ID# 68-0295333

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Name (Printed) \_\_\_\_\_