pacific medical centers

REGISTRATION FORM

PATIENT INFORMATION

Last Name (Legal)	First Name, Middle Name (Legal)		Preferred Name	
Previous Name(s)	Social Security Number	Sex ☐ Female ☐ Male ☐ Other	Date of Birth	Marital Status
Gender Identity ☐ Female ☐ Transgender Female / Male to Female ☐ Other / Non-Binary ☐ Male ☐ Transgender Male / Female to Male ☐ Prefer Not to Disclose	Patient Preferred Pronouns ☐ She / Her ☐ He / Him ☐ They / Them		Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline	
Address	City		State	Zip Code
Home Phone	Work Phone	Cell Phone		Email
Preferred Language / Need Interpreter ☐ Yes ☐ No	Communication Assistance ☐ Hearing ☐ Speech ☐ Vision ☐ Other	Race ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Native Hawaiian or other Pac Islander ☐ Other ☐ Decline		
Employer Name	Employment Status ☐ Full Time ☐ Part Time ☐ Student ☐ Active Military ☐ Disabled ☐ Unemployed ☐ Retired		Retirement Date (if applicable)	Occupation
Emergency Contact Name	Emergency Contact Number		Relationship	
Primary Care Provider	Primary Care Provider Phone #	Referred? ☐ Yes ☐ No	Referred by Name/Phone #	

GUARANTOR/LEGAL GUARDIAN (If patient is 18 or older, guarantor is self)

Does adult patient have "legal guardian" or durable power of attorney for health care? (If Yes, please complete the fields below and provide guardianship court order or durable power of attorney for health care document)			
Last Name	First Name, Middle Name	Relation to Patient	
Home Phone	Social Security Number	Sex ☐ Female ☐ Male ☐ Other	Date of Birth
Address	City	State	Zip Code
Employer Name	Employment Status ☐ Full Time ☐ Part Time ☐ Student ☐ Active Military ☐ Disabled ☐ Unemployed ☐ Retired	Retirement Date (if applicable)	Occupation

PRIMARY INSURANCE

Insurance Company Name	Group Number	Subscriber ID Number		Copay Amount
Subscriber's Name (Policy Holder)	Social Security Number	Date of Birth	Sex ☐ Female ☐ Male ☐ Other	Relationship to Patient
Subscriber's Employer Name	Subscriber Employment Status	Subscriber Home Phone		Subscriber Work Phone

SECONDARY INSURANCE

Insurance Company Name	Group Number	Subscriber ID Number		Copay Amount
Subscriber's Name (Policy Holder)	Social Security Number	Date of Birth	Sex ☐ Female ☐ Male ☐ Other	Relationship to Patient
Subscriber's Employer Name	Subscriber Employment Status	Subscriber Home Phone		Subscriber Work Phone

Print Name	Date	Print Name	Date
Patient Signature		Guardian/Legal Representative Signature	

PATIENT LABEL HERE

Pacific Medical Centers complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

- **中文** (Chinese) **注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電** 1-888-4PACMED （TTY：711）
- Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-4PACMED (TTY: 711).
- Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-4PACMED (TTY: 711).

**We value your privacy and may share your contact information with trusted partners to assist us in enhancing your experience with PacMed. Your medical information is never shared.