PATIENT REGISTRATION FORM

Name:	
DOB:	Age:
Marital Status:	SSN:
Address (no P.O. boxes):	
Email:	
Mobile phone:	Home phone:
Best place to leave a confidential message: ☐ email ☐ mobile ☐ home phone	
Emergency Contact:	Relation:
Emergency Contact Phone:	

HEALTH INSURANCE INFORMATION

Insurance company:	Policy or ID #:	Group#:
Insurance address:		
	Insurance phone #:	
Subscriber/employee name:	Subscriber DOB:	
Relation to patient:	Employer:	
Secondary insurance, if any:		

PRIVACY PRACTICES

This medical practice's Notice of Privacy Practices ("Notice") can be found at www.marinintegrativepsychiatry.com under Policies. A paper copy will be provided to you at your request. This notice should be reviewed carefully. It contains information about the privacy rights of patients and how the doctor may use and disclose your protected health information. If you have any questions about your rights or our privacy practices, please contact Dr. do Valle directly.

By signing below, you acknowledge receipt of the Notice of Privacy Practices.

Patient Signature: Date: