

Patient Registration Form

TODAYS DATE _____

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____ SSN# _____

MARITAL STATUS _____ SEX _____
(Single/Married/Divorced/Widowed/Other) (Male/Female)

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME# () _____ WORK# () _____

PREFERRED CONTACT NUMBER () _____
(Where we can leave you a message)

EMAIL ADDRESS _____
(will not be distributed outside of OCIM)

INSURANCE CARRIER _____

Are you new to UCSF Medical Center? _____

Emergency Contact

LAST NAME _____ FIRST NAME _____

(RELATION) _____ TELEPHONE# () _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Referral Information

Your response will let us know whom to thank!

1. How did you hear about us for the first time?
{Please mark choice}

From an Individual:

(Please Provide Name)

- UCSF Physician: _____
- UCSF Department: _____
- Non-UCSF Physician: _____
- Osher Center Program: _____
- Friend, family member, or UCSF Patient: _____
- Other: _____

From Website:

- UCSF Medical Center website
- Osher Center for Integrative Medicine (OCIM) website
- Online Advertisement

From Print/Media:

- OCIM brochure
- OCIM flyer
- Signage
- Television or radio announcement
- Other: _____

Specific location is greatly appreciated:

From UCSF Publication:

- To Our Neighbors
- UCSF Online Calendar
- Newsbreak
- Other: _____

From a Non-UCSF Publication: _____ (which one?)

At an Event _____ (which one?)

Other: _____

2. What services are you here to receive?

- Integrative Medicine Consult
- Massage Therapy
- Nutrition Consult
- Biofeedback
- Acupuncture
- Spinal Manipulation
- Psychotherapy/Integrative Psychiatry

3. Is this your first visit to UCSF as a patient? **Yes** **No**