Osher Center for Integrative Medicine at UCSF 1545 Divisadero St., 4th Floor San Francisco CA 94115

Phone: 415/353-7720 Fax: 415/353-7358

**Patient Registration Form**

**TODAYS DATE**

**LAST NAME FIRST NAME**

**DATE OF BIRTH**

**SSN#**

**MARITIAL 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 ADRRESS**

**(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  Acupuncture

 Massage Therapy  Spinal Manipulation

 Nutrition Consult  Psychotherapy/Integrative Psychiatry

 Biofeedback

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