- ☐ MGH Ankle & Foot
- ☐ MGH Eye Clinic
- ☐ MGH Family Health
- ☐ MGH Surgery Clinic
- ☐ MGH Olympic Physicians
- ☐ MGH Shelton Orthopedics
- ☐ MGH Mountain View Women's Health
- ☐ MGH Oakland Bay Pediatrics
- ☐ MGH Shelton Family Medicine
- ☐ MGH Hoodsport Clinic

Legal Name (Last, First MI): ____ **Other Name:** _______________

Gender: ☐*Female* ☐*Male* **SSN:** ___________________________ **Date of Birth:** _________________________

Race: ☐*Caucasian/White* ☐*Black* ☐*Unknown* ☐*Eskimo* ☐*Hispanic/Latino* ☐ *American Indian* ☐ *Asian*

☐*Pacific Islander/Native Hawaiian* ☐*Other:* _____________ **Ethnicity:** ☐*Hispanic* ☐*Non-Hispanic*

Address: __________________________________ **City:** _______________ **State:** ____ **Zip Code:** __________

Residence: ________________________________ **City:** _______________ **State:** ____ **Zip Code:** __________

Home Phone: ____________________ **Cell:** _____________________ **May we leave a detailed Message Y/N**

Marital Status: ☐*Single* ☐*Married* ☐*Divorced* ☐*Widowed* ☐*Other:* ____

Language: ___________________ **Religion:** _________________ **Email:** _______________________________

Employment Status: ☐*Full Time* ☐*Part Time* ☐*Self-employed* ☐*Retired-Date:* _____________ ☐*Student* ☐*Child* ☐*Unemployed*

Employer: ______________________________________**Employer Address:**___________________________

Occupation: ________________________________**Work Number:** __________________________________

Primary Care Provider: _________________ ____

Guarantor Name: ______________________________________ *Self* ☐*Spouse* ☐*Parent* ☐*Other* ________________

Primary Insurance: ______________________________**Insured**: ☐*Self* ☐*Spouse*☐*Parent*☐*Other*_______________

ID #: ______________________________________ **Group #:** _______________________________________

Policy Holder: ____**DOB:** ______________________

☐*Full Time* ☐*Part Time* ☐*Self-employed* ☐*Retired* **Policy Holders Employer:** ________________________________

Secondary Insurance: ____________________________**Insured:** ☐ *Self* ☐*Spouse* ☐*Parent* ☐*Other* _________

ID #: ______________________________________ **Group #:** _______________________________________

Policy Holder: ____ **DOB:** _____________________

☐*Full Time* ☐*Part Time* ☐*Self-employed* ☐*Retired* **Policy Holders Employer:** ________________________________

Emergency Contact: ________________________ **Patient Relation to EC:** __________ **Phone:**_____________

____ ________________________ ___________________

Signature (Patient, Parent, Legal Representative) **Relationship to Patient** **Date**

- ❐ MGH Ankle & Foot
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- ❐ MGH Shelton Family Medicine
- ❐ MGH Hoodsport Clinic

Next of Kin: _________________________Patient Relation to NOK: ___________ Phone: ________________

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Signature (Patient, Parent, Legal Representative) Relationship to Patient Date