ADELANTE HEALTHCARE

PATIENT REGISTRATION

AA54.PT.FRM

PATIENT INFORMATION

PATIENT NAME:	TODAY'S DATE:
IF CHILD - PARENT NAME:	IF CHILD - PARENT NAME:
DATE OF BIRTH (Month/Day/Year):	RELATIONSHIP STATUS: ☐ SINGLE ☐ DOMESTIC PARTNER ☐ MARRIED
HOME ADDRESS:	
CITY, STATE, ZIP:	BEST CONTACT NUMBER: ( )
EMAIL ADDRESS:	
EMPLOYER NAME & ADDRESS:	
WORK PHONE: ( )	☐ CHECK THIS BOX IF PATIENT HAS NO INSURANCE

EMERGENCY CONTACT INFORMATION

NAME:	HOME PHONE:
ADDRESS:	SECONDARY HOME PHONE:
CITY, STATE, ZIP:	DAY PHONE:
RELATIONSHIP:	CELL PHONE:
	ALTERNATE PHONE:

ADDITIONAL INFORMATION

PRIMARY LANGUAGE:

RACE: SELECT AS MANY AS APPLY

- ☐ ASIAN
- ☐ NATIVE HAWAIIAN
- ☐ OTHER PACIFIC ISLANDER
- ☐ BLACK/AFRICAN AMERICAN
- ☐ AMERICAN INDIAN/ALASKA NATIVE
- ☐ WHITE
- ☐ DECLINE TO SPECIFY

ETHNICITY:

- ☐ HISPANIC/LATINO
- ☐ DECLINE TO SPECIFY
- ☐ NOT HISPANIC/LATINO

WHICH GENDER WERE YOU ASSIGNED AT BIRTH?

- ☐ MALE
- ☐ FEMALE
- ☐ DECLINE TO SPECIFY

DO YOU IDENTIFY AS:

- ☐ CHOOSE NOT TO DISCLOSE
- ☐ BISEXUAL
- ☐ DON'T KNOW
- ☐ LESBIAN OR GAY
- ☐ SOMETHING ELSE
- ☐ STRAIGHT NOT LESBIAN OR GAY

WHAT IS YOUR CURRENT GENDER IDENTITY?

- ☐ CHOOSE NOT TO DISCLOSE
- ☐ FEMALE
- ☐ MALE
- ☐ OTHER
- ☐ TRANSGENDER FEMALE MTF
- ☐ TRANSGENDER MALE FTM

ARE YOU A VETERAN? ☐ YES ☐ NO	
ARE YOU HOMELESS? ☐ YES ☐ NO IF YES: WHERE DO YOU STAY? ☐ SHELTER ☐ TRANSITIONAL HOUSING ☐ WITH OTHERS ☐ STREET ☐ UNKNOWN/UNREPORTED ☐ DOUBLING UP	HAS THE PRIMARY SOURCE OF WORK FOR YOU OR A FAMILY MEMBER EVER BEEN FARM WORK (SEASONAL / MIGRANT)? ☐ YES ☐ NO (IF NO – YOU HAVE COMPLETED THIS SECTION) HAVE YOU OR A FAMILY MEMBER EVER MOVED TO FOLLOW FARM WORK? ☐ YES ☐ NO FOR ANY FAMILY MEMBER THAT NO LONGER DOES FARM WORK IS IT BECAUSE THEY ARE DISABLED OR TOO OLD TO WORK? ☐ YES ☐ NO
FAMILY SIZE _____ (how many in the household) ESTIMATED INCOME _____ ☐ Monthly ☐ Annually	NAME OF HEAD OF HOUSEHOLD _____ DATE OF BIRTH _____
PERSON RESPONSIBLE FOR CHARGES IF OTHER THAN PATIENT	
NAME:	EMPLOYER:
ADDRESS:	HOME PHONE:
CITY, STATE, ZIP:	WORK PHONE:
DATE OF BIRTH:	CELL PHONE:
WHOM MAY WE THANK FOR YOUR REFERRAL TO US?	

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all health services provided by Adelante Healthcare regardless of whether I have insurance or not. I understand that while Adelante Healthcare contracts with many insurance companies, it is my responsibility to verify with my plan that Adelante Healthcare is a participating provider. I hereby consent to authorize all examinations including physical exams, x-ray and laboratory procedures, which may be necessary in the judgment of the provider for diagnostic purposes. I authorize Adelante Healthcare staff to take photographs, I understand that these photographs will be used as a record of my care and for identification purpose. If used, any identifying information will be kept confidential. I understand I will not receive any form of compensation for these photographs.

It is very important for you to keep all scheduled appointments. If you are unable to keep an appointment you must notify us as soon as possible – we ask for 24 hour notice so we can use those appointment times for other patients. Three missed appointments in a 12 month period will result in a standby appointments status and may lead to a dismissal from the practice.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE