

PATIENT INFORMATION

PATIENT NAME:		TODAY'S DATE:
IF CHILD - PARENT NAME:	IF CHILD - PARENT NAME:	
DATE OF BIRTH (Month/Day/Year):	RELATIONSHIP STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> MARRIED	
HOME ADDRESS:		
CITY, STATE, ZIP:	BEST CONTACT NUMBER: ()	
EMAIL ADDRESS:		
EMPLOYER NAME & ADDRESS:		
WORK PHONE: ()	<input type="checkbox"/> 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 <input type="checkbox"/> ASIAN <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> BLACK/AFRICAN AMERICAN <input type="checkbox"/> AMERICAN INDIAN/ALASKA NATIVE <input type="checkbox"/> WHITE <input type="checkbox"/> DECLINE TO SPECIFY	ETHNICITY: <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> DECLINE TO SPECIFY <input type="checkbox"/> NOT HISPANIC/LATINO WHICH GENDER WERE YOU ASSIGNED AT BIRTH? <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> DECLINE TO SPECIFY
DO YOU IDENTIFY AS: <input type="checkbox"/> CHOOSE NOT TO DISCLOSE <input type="checkbox"/> BISEXUAL <input type="checkbox"/> DON'T KNOW <input type="checkbox"/> LESBIAN OR GAY <input type="checkbox"/> SOMETHING ELSE <input type="checkbox"/> STRAIGHT NOT LESBIAN OR GAY	WHAT IS YOUR CURRENT GENDER IDENTITY? <input type="checkbox"/> CHOOSE NOT TO DISCLOSE <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE <input type="checkbox"/> OTHER <input type="checkbox"/> TRANSGENDER FEMALE MTF <input type="checkbox"/> TRANSGENDER MALE FTM

ARE YOU A VETERAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	
ARE YOU HOMELESS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES: WHERE DO YOU STAY? <input type="checkbox"/> SHELTER <input type="checkbox"/> TRANSITIONAL HOUSING <input type="checkbox"/> WITH OTHERS <input type="checkbox"/> STREET <input type="checkbox"/> UNKNOWN/UNREPORTED <input type="checkbox"/> DOUBLING UP	HAS THE PRIMARY SOURCE OF WORK FOR YOU OR A FAMILY MEMBER EVER BEEN FARM WORK (SEASONAL / MIGRANT)? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO – YOU HAVE COMPLETED THIS SECTION) HAVE YOU OR A FAMILY MEMBER EVER MOVED TO FOLLOW FARM WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO FOR ANY FAMILY MEMBER THAT NO LONGER DOES FARM WORK IS IT BECAUSE THEY ARE DISABLED OR TOO OLD TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO
FAMILY SIZE _____ (how many in the household) ESTIMATED INCOME _____ <input type="checkbox"/> Monthly <input type="checkbox"/> 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