ADELANTE HEALTHCARE

# PATIENT REGISTRATION

AA54.PT.FRM

## PATIENT INFORMATION

| | |
|---|---|
| PATIENT NAME: | TODAY'S DATE: |
| IF CHILD - PARENT NAME: | IF CHILD - PARENT NAME: |
| PATIENT DATE OF BIRTH (Month/Day/Year): | PATIENT RELATIONSHIP STATUS:<br>☐ SINGLE ☐ DOMESTIC PARTNER ☐ MARRIED |
| HOME ADDRESS: | |
| CITY, STATE, ZIP: | PRIMARY CONTACT NUMBER:( )<br>☐ Home ☐ Cell |
| | SECONDARY CONTACT NUMBER:( )<br>☐ Home ☐ Cell |
| EMAIL ADDRESS: | |

## ADDITIONAL INFORMATION

PRIMARY LANGUAGE:

☐ CHECK THIS BOX IF PATIENT HAS NO INSURANCE

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

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

PREFERRED PRONOUN:

- ☐ ASKED BUT UNKNOWN
- ☐ DECLINE TO ANSWER
- ☐ HE, HIM, HIS
- ☐ SHE, HER, HERS
- ☐ THEY, THEM, THEIRS
- ☐ OTHER:_____
- ☐ ZE, HIR

ARE YOU HOMELESS?

☐ YES ☐ NO

IF YES: WHERE DO YOU STAY?

☐ SHELTER

☐ TRANSITIONAL HOUSING

☐ STREET

☐ UNKNOWN/UNREPORTED

☐ DOUBLING UP

DO YOU LIVE IN PUBLIC HOUSING?

☐ Yes ☐ No

ARE YOU A VETERAN? ☐ YES ☐ NO

LANGUAGE BARRIER WITH ENGLISH? ☐ YES ☐ NO

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? (MIGRANT)

☐ YES ☐ NO

FOR ANY FAMILY MEMBER THAT NO LONGER DOES FARM WORK IS IT BECAUSE THEY ARE DISABLED OR TOO OLD TO WORK? (MIGRANT)

☐ YES ☐ NO

IS THE PRIMARY SOURCE OF WORK FOR YOU OR A FAMILY MEMBER FARM WORK ON A SEASONAL BASIS? (SEASONAL)

☐ YES ☐ NO

## EMERGENCY CONTACT INFORMATION

| NAME: | BEST CONTACT NUMBER: |
|---|---|
| RELATIONSHIP: | WORK PHONE: |

PATIENT/GUARDIAN SIGNATURE

DATE