ADELANTE HEALTHCARE

PATIENT REGISTRATION FORM

AC16.DENT.FRM

PATIENT INFORMATION

PATIENT NAME:		TODAY'S DATE:
IF CHILD:	MOTHER'S NAME	FATHER'S NAME
☐ MALE ☐ FEMALE	DATE OF BIRTH:	RELATIONSHIP STATUS: ☐ SINGLE ☐ SPOUSE/PARTNER ☐ WIDOWED ☐ DIVORCED
HOME ADDRESS:		
CITY, STATE,ZIP:		BEST CONTACT NUMBER: ( )
EMAIL ADDRESS:		
EMPLOYER NAME & ADDRESS:		
WORK PHONE: ( )		☐ CHECK THIS BOX IF PATIENT HAS NO INSURANCE
DO YOU SEE ONE OF OUR ADELANTE HEALTHCARE PROVIDERS FOR YOUR MEDICAL CARE? ☐ YES ☐ NO		

EMERGENCY CONTACT INFORMATION

NAME:	HOME PHONE:
ADDRESS:	WORK PHONE:
CITY, STATE, ZIP:	CELL PHONE:

ADDITIONAL INFORMATION

PRIMARY LANGUAGE:

ARE YOU A VETERAN: ☐ YES ☐ NO

RACE:
- ☐ ASIAN
- ☐ NATIVE HAWAIIAN
- ☐ OTHER PACIFIC ISLANDER
- ☐ BLACK/AFRICAN AMERICAN
- ☐ AMERICAN INDIAN/ALASKA NATIVE
- ☐ WHITE/CAUCASIAN
- ☐ MORE THAN ONE RACE
- ☐ PREFER NOT TO REPORT

ETHNICITY:
- ☐ HISPANIC/LATINO
- ☐ NOT HISPANIC/LATINO
- ☐ PREFER NOT TO REPORT

DO YOU HAVE AN ADVANCED DIRECTIVE
☐ YES ☐ NO

IF YES – PLEASE PROVIDE A COPY TO OUR OFFICE STAFF
IF NO – YOU MAY OBTAIN INFORMATION ON ADVANCED DIRECTIVES FROM OUR STAFF

ARE YOU HOMELESS
☐ YES ☐ NO

IF YES: WHERE DO YOU STAY:
- ☐ SHELTER
- ☐ TRANSITIONAL HOUSING
- ☐ WITH OTHERS
- ☐ STREET
- ☐ OTHER

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

IF YOU NEED ASSISTANCE WITH THIS SECTION
PLEASE ASK ONE OF OUR STAFF FOR ADDITIONAL INFORMATION

PLEASE INDICATE WHAT LETTER CATGORY YOUR FAMILY SIZE AND INCOME REPRESENT (SEE ATTACHED SHEET)	☐ A ☐ B ☐ C ☐ D ☐ F

PERSON RESPONSIBLE FOR CHARGES IF OTHER THAN PATIENT / HEAD OF HOUSEHOLD	
NAME:	EMPLOYER:
ADDRESS:	HOME PHONE:
CITY, STATE, ZIP:	WORK PHONE:
DATE OF BIRTH:	CELL PHONE:

INSURANCE INFORMATION
IF PATIENT HAS NO INSURANCE DO NOT FILL OUT THIS SECTION

PRIMARY INSURANCE	**SECONDARY INSURANCE**
INSURANCE NAME:	INSURANCE NAME:
CLAIMS ADDRESS:	CLAIMS ADDRESS:
☐ EMPLOYER GROUP PLAN ☐ INDIVIDUAL PLAN	☐ EMPLOYER GROUP PLAN ☐ INDIVIDUAL PLAN
SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ PARENT	SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ PARENT
SUBSCRIBER NAME:	SUBSCRIBER NAME:
SUBSCRIBER DOB:	SUBSCRIBER DOB:
MEMBER ID:	MEMBER ID:
GROUP #:	GROUP #:

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 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. It is my responsibility to know what is or is not a covered service. It is also my responsibility to find out what my coverage options are with my insurance plan. We reserve the right to charge a fee for overdue accounts and returned checks. I further understand that I authorize Adelante Healthcare to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that Adelante Healthcare uses an external collection agency in order to collect on any past due accounts and if my bill is not paid in full after 60 days from the date of service my account may be turned over to this agency.

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 - 48 hour notice so we can use those appointment times for other patients. Frequently missed appointments may result in dismissal from the practice.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE