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: ☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER
HOME ADDRESS:	
CITY, STATE, ZIP:	PRIMARY CONTACT NUMBER:( ) ☐ Home ☐ Cell
	SECONDARY CONTACT NUMBER:( ) ☐ Home ☐ Cell
EMAIL ADDRESS:	

ADDITIONAL INFORMATION

PRIMARY LANGUAGE:

☐ CHECK THIS BOX IF PATIENT HAS NO INSURANCE

RACE: SELECT AS MANY AS APPLY

- ☐ AMERICAN INDIAN OR ALASKA NATIVE
- ☐ ASIAN INDIAN
- ☐ CHINESE
- ☐ KOREAN
- ☐ JAPANESE
- ☐ VIETNAMESE
- ☐ OTHER ASIAN
- ☐ FILIPINO
- ☐ GUAMANIAN OR CHAMORRO
- ☐ NATIVE HAWAIIAN
- ☐ OTHER PACIFIC ISLANDER
- ☐ SAMOAN
- ☐ MORE THAN ONE RACE
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ WHITE
- ☐ DECLINE TO SPECIFY

ETHNICITY:

- ☐ CUBAN
- ☐ PUERTO RICAN
- ☐ MEXICAN, MEXICAN AMERICAN, CHICANO/A
- ☐ ANOTHER HISPANIC, LATINO/A, OR SPANISH ORIGIN
- ☐ NOT HISPANIC, LATINO/A, OR SPANISH ORIGIN
- ☐ DECLINE TO SPECIFY

WHICH GENDER WERE YOU ASSIGNED AT BIRTH?

- ☐ MALE
- ☐ FEMALE

DO YOU IDENTIFY AS:

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

WHAT IS YOUR CURRENT GENDER IDENTITY?

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

Preferred Pronoun:

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

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