ADELANTE HEALTHCARE

# NEW PATIENT REGISTRATION

AA53.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<br>SECONDARY CONTACT NUMBER: ☐ HOME ☐ CELL |
| EMAIL ADDRESS: | |

## ADDITIONAL INFORMATION

**HAVE YOU BEEN SEEN AT ANY ADELANTE LOCATION?** ☐ YES ☐ NO

IF YES, PLEASE SELECT LOCATION:

- ☐ BUCKEYE
- ☐ CENTRAL PHOENIX
- ☐ GILA BEND
- ☐ GOODYEAR
- ☐ MESA
- ☐ MEDICAL MOBILE UNIT
- ☐ PEORIA
- ☐ SURPRISE
- ☐ WEST PHOENIX
- ☐ WICKENBURG
- ☐ SOMEWHERE ELSE: ________________

**WHO MAY WE THANK FOR YOUR REFERRAL?**

- ☐ ADVERTISEMENT ________________
- ☐ EMPLOYEE
- ☐ EVENT________________
- ☐ FAMILY OR FRIEND
- ☐ HOSPITAL
- ☐ INSURANCE PLAN ________________
- ☐ WIC
- ☐ OTHER ________________

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

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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:

RELATIONSHIP:

BEST CONTACT NUMBER:

PATIENT/GUARDIAN SIGNATURE

DATE