

## 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: <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:	BEST CONTACT NUMBER:
RELATIONSHIP:	WORK 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

<p>ARE YOU HOMELESS?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IF YES: WHERE DO YOU STAY?</p> <p><input type="checkbox"/> SHELTER</p> <p><input type="checkbox"/> TRANSITIONAL HOUSING</p> <p><input type="checkbox"/> WITH OTHERS</p> <p><input type="checkbox"/> STREET</p> <p><input type="checkbox"/> UNKNOWN/UNREPORTED</p> <p><input type="checkbox"/> DOUBLING UP</p>	<p>HAS THE PRIMARY SOURCE OF WORK FOR YOU OR A FAMILY MEMBER EVER BEEN FARM WORK (SEASONAL / MIGRANT)?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO – YOU HAVE COMPLETED THIS SECTION)</p> <p>HAVE YOU OR A FAMILY MEMBER EVER MOVED TO FOLLOW FARM WORK?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>FOR ANY FAMILY MEMBER THAT NO LONGER DOES FARM WORK IS IT BECAUSE THEY ARE DISABLED OR TOO OLD TO WORK?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>ARE YOU A VETERAN? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p><b>PERSON RESPONSIBLE FOR CHARGES IF OTHER THAN PATIENT</b></p>	
<p>NAME:</p>	<p>EMPLOYER:</p>
<p>ADDRESS:</p>	<p>HOME PHONE:</p>
<p>CITY, STATE, ZIP:</p>	<p>WORK PHONE:</p>
<p>DATE OF BIRTH:</p>	<p>CELL PHONE:</p>
<p>WHOM MAY WE THANK FOR YOUR REFERRAL TO US?</p>	

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. **As a teaching institution there may be trainees involved in my care, I understand that I have the right to refuse their services at any time.**

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.

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.

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