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 ☐ DOMESTIC PARTNER ☐ MARRIED
HOME ADDRESS:	
CITY, STATE, ZIP:	BEST CONTACT NUMBER: ( )
EMAIL ADDRESS:	
EMPLOYER NAME & ADDRESS:	
WORK PHONE: ( )	☐ 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

- ☐ 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
- ☐ DECLINE TO SPECIFY

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?	HAS THE PRIMARY SOURCE OF WORK FOR YOU OR A FAMILY MEMBER EVER BEEN FARM WORK (SEASONAL / MIGRANT)?
☐ YES ☐ NO	☐ YES ☐ NO (IF NO – YOU HAVE COMPLETED THIS SECTION)
IF YES: WHERE DO YOU STAY? ☐ SHELTER ☐ TRANSITIONAL HOUSING ☐ WITH OTHERS ☐ STREET ☐ UNKNOWN/UNREPORTED ☐ DOUBLING UP	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
ARE YOU A VETERAN? ☐ YES ☐ NO	

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

WHOM MAY WE THANK FOR YOUR REFERRAL TO US?

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 ____________________