Adult Registration Form

☐ New Patient ☐ Edit Information

*****For All Patients over 18 years of Age *****

Please complete this form to ensure proper billing of your services. **Please Print.** Today's Date: ______________

Patient Information

Please provide Photo ID

Patient Last Name: ______________________________

First Name: ______________________ MI: ________

Preferred Name: ______________________________

Date of Birth: ______________________________

Gender:
☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F
☐ Decline to specify

Marital Status:
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
☐ Life Partner ☐ Significant Other
☐ Other ______________________________

Student Status:
☐ Full-time ☐ Part-time ☐ N/A

Ethnicity:
☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Declined to specify

Race:
☐ American Indian/Alaska Native ☐ Asian
☐ African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Declined to specify

Preferred Language:
☐ English ☐ Spanish
☐ Other ______________________________

Translator?
☐ YES ☐ NO

Comments: ______________________________

Patient's Primary Address

Address: ______________________________

City, State, Zip: ______________________________

Home Phone: (______) ________________ Cell Phone: (______) ________________ Work Phone: (______) ________________

Patient's Reminders/Communication

This section is relative to preferred method of communication and Patient Portal access

Due to HIPAA regulations all patients over 18 must use their own information unless a legal guardian/court document is supplied.

Home Phone: (______) ________________ Cell Phone: (______) ________________ Work Phone: (______) ________________

☐ Web Enabled E-Mail: ______________________________
☐ No Email ☐ Patient Refused

☐ Voice Enabled Messaging ☐ English ☐ Spanish **Preferred method:** ☐ Home ☐ Cell ☐ Work
☐ Text Enabled Messaging ☐ English ☐ Spanish **Preferred method:** ☐ Home ☐ Cell ☐ Work

Types of reminders you wish to receive:
☐ Appointments ☐ Lab results ☐ Health Maintenance ☐ RX Confirmation ☐ General ☐ **ALL** ☐ **NONE**

Patient's Employment Information

Emp. Status:
☐ Employed FT ☐ Employed PT ☐ Not Employed ☐ Self ☐ Active Military ☐ Retired ☐ Reserved for Nat'l assignment

Employer: ______________________________ Occupation: ______________________________

Preferred Pharmacy Information

Primary Pharmacy Name, Address & Phone #: ____________________

____

Patient's Emergency Contact

Last Name, First Name: ____________________ Patient's Relationship to Contact: ____________________

Home Phone: (______) ____________________

Work Phone: (______) ____________________

Cell Phone: (______) ____________________

Insurance Information

Please provide a copy of ALL Insurance cards

Please let us know if this is a ☐ Worker's Comp Issue ☐ MVA ☐ Legal Case ☐ School Insurance

☐ Self-Pay (no insurance)

☐ Medicaid – ID Number: ____________________

Patient relationship to Insured:

☐ Self ☐ Spouse ☐ Child ☐ Other ____________________

PRIMARY INSURANCE NAME:

Benefit Plan Name ____________________

Member ID: ____________________

Group#: ____________ Effective Date: ____________

Subscriber's Name: ____________________

Subscriber's DOB: ____________________

Gender:

☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F

☐ Decline to specify

PCP listed on Card: ____________________

SECONDARY INSURANCE NAME:

Benefit Plan Name ____________________

Member ID: ____________________

Group#: ____________ Effective Date: ____________

Subscriber's Name: ____________________

Subscriber's DOB: ____________________

Gender:

☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F

☐ Decline to specify

PCP listed on Card: ____________________

I have completed this form to the best of my knowledge and I understand I am to contact the office with changes to my personal information. I understand that I am responsible for all outstanding patient liabilities and financial obligations.

Patient Name: ____________________ *Date:* ____________

Patient Signature: ____________________

If Patient has a Legal Guardian, a copy of the legal document granting you such power must be attached or on file with Advocare LLC.