

Adelante Healthcare PATIENT REGISTRATION

Patient Information

First Name:		MI:	Last Name:		Other Names Used:	
Mailing Address:			City:	State:	Zip Code:	
Street Address:			City:	State:	Zip Code:	
Home Phone #: ()			Work or Cell Phone #: ()			
Birth Date:		Social Security #:		Sex: M F	Referred By:	
Marital Status:		Single	Single w/Partner	Married	Divorced	Separated Widowed
Race:		White	Hispanic	Black	Native American	Asian Other
Reason for Visit:				E-Mail Address:		
If due to accident, please circle what type:				Auto	Work	Slip/Fall Other

Insurance Information (Please Present Insurance Cards for Copying)

Do You Have:		Insurance	AHCCCS	Medicare	None	Other
Primary Insurance Name:			ID #:	Group #:		
Secondary Insurance Name:			ID #:	Group #:		

Responsible Person's Information (must be adult over 18 years old)

First Name:		MI:	Last Name:		Sex: M F	
Birth Date:		Social Security #:		Relation to Patient:		

Employment Information

Person Financially Responsible (Head of Household):						
Employer's Name:				Occupation:		
Employer's Address:			City:	State:	Zip Code:	
Phone Number: ()				Driver's License #:		

Emergency Information

Emergency Contact Name:			Emergency #: ()			
Address:			Relation to Patient:			

Other Family Members

First Name	MI	Last Name	Sex	Birth Date	Social Security #	Insurance Information	

I hereby attest, that the information above is true and correct to the best of my knowledge. I understand and agree that I am ultimately responsible for the balance of my account, for any and all professional services rendered. Should I for any reason be determined ineligible for insurance benefits, I or the person responsible for me, will the amount billed in full within 30 days of receiving notice. I authorize payment of medical benefits directly to Adelante Healthcare. I authorize the release of any medical information necessary to process nay medical claim.

If there is anyone you authorize us to speak with regarding your medical care, please print their name and relationship below. Please note that this person will remain authorized to receive information until you provide written documentation to the contrary.

Name: _____ Relationship: _____

Signature of Patient or Patient's Representative: _____ Date: _____