PATIENT REGISTRATION FORM

AdventistHealth

(Please give your insurance card to the receptionist.)

*** Indicates required information to be completed by patient**

PATIENT INFORMATION				
***Last Name:**	***First Name:**	**Middle:** Suffix:		Preferred Name:
***Sex:** ❑ **M** ❑ **F**	***Date of Birth: / /**	Preferred Language:		Race:
Gender Identity (circle one): Choose not to Disclose / Female / FTM – Transgender Female to Male / Gender Queer / Male / MTF – Transgender Male to Female / Non-Binary / Other		Written Language:		***Ethnicity:**
Marital status (circle one): Divorced / Legally Separated / Life-Domestic Partner/ Married / Single / Unknown / Widowed		Religion:		Student Status:
Email Address:		***Social Security SSN: - -**		

MAILING ADDRESS				
***Mailing Address Line 1:**		Mailing Address Line 2:		
***Country:**	***Zip Code:**	***City:**	***State:**	***County:**

PHYSICAL ADDRESS (IF DIFFERENT FROM MAILING ADDRESS)				
Physical Address Line 1:		Physical Address Line 2:		
Country:	Zip Code:	City:	State:	County:

CONTACT INFORMATION			
***Home Phone:** **( )**	Mobile Phone: ( )	Work Phone: ( ) Ex:	Preferred Phone Type: (circle one) Home / Mobile / Work

EMPLOYER			
Employer:			
Employer Address Line 1:		Employer Address Line 2:	
Country:	Zip Code:	City:	State:
Business Phone: ( ) Ex.		Contact:	
Employment Status: (circle one) (Active Military Duty / Full-Time/ Never Employed / Part-Time / Retired / Self Employed / Unemployed / Unknown	Occupation:	Hire Date: / / End Date: / / Retire Date: / /	

PROVIDER	
***Primary Care Physician:**	Phone Number: ( )

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MY ADVENTIST HEALTH (PATIENT PORTAL)		
I would like to sign up for My Adventist Health ❑ YES ❑ NO *If yes, complete this section.		
***E-Mail Address:**	***Challenge Question:** (circle one) Last four digits of your SSN? What Year did you graduate high school? What year was your first child born? What year was your mother born?	***Challenge Answer:**

GUARANTOR				
***Last Name:** Suffix:	***First Name:**	**Middle:**	Preferred Name:	
***Sex: ❑ M ❑ F**	***Date of Birth: / /**	***Social Security SSN:**		
***Mailing Address Line 1:**	Mailing Address Line 2:			
***Country:**	***Zip Code:**	***City**	***State:**	***County:**
***Home Phone:** **( )**	Mobile Phone: ( )	Work Phone: ( ) Ex.	E-mail Address:	
Guarantor Employer:				
Employer Address Line 1:	Employer Address Line 2:			
Country:	Zip Code:	City:	State:	
Business Phone:	Extension:	Contact:		
Employment Status (circle one): Active Military Duty / Full-Time / Never Employed / Part-Time / Retired / Self Employed / Unemployed / Unknown	Occupation:	Hire Date: / / End Date: / / Retire Date: / /		

RELATED PERSON				
Role (circle one): Emergency Contact / Guardian / Next of Kin / Power of Attorney	Type (circle one): Aunt / Brother / Cadaver Donor / Daughter / Employee / Father / Life Partner / M. Grandfather / M. Grandmother / Mother / Organ Donor / Other / P. Grandfather / P. Grandmother / Sister / Son / Spouse / Uncle			
Last Name: Suffix:	First Name:	Middle:	Preferred Name:	
Sex: ❑ M ❑ F	Date of Birth: / /	Social Security SSN:		
Address Line 1:	Address Line 2:			
Country:	Zip Code:	City	State:	County:
Home Phone: ( )	Mobile Phone: ( )	Work Phone: ( ) Ex.	E-mail Address:	

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INSURANCE				
Accident Related? ❑ yes ❑ No				
Name of **Primary** Health Plan:				
Insurance Address Line 1:		Insurance Address Line 2:		
Country:	Zip Code:	City:	State:	County:
Plan Begin Date: / /		Plan End Date: / /		
Member Number:	Group Number:	Group Name:		
Insured Name on Card: Last Name: Suffix:		First Name:		Middle Name:

Name of **Secondary** Health Plan (if applicable):				
Insurance Address Line 1:		Insurance Address Line 2:		
Country:	Zip Code:	City:	State:	County:
Plan Begin Date: / /		Plan End Date: / /		
Member Number:	Group Number:	Group Name:		
Insured Name on Card: Last Name: Suffix:		First Name:		Middle Name:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Adventist Health or insurance company to release any information required to process my claims.

____ _____________________________

Patient/Guardian Signature Date

Guardian Name (print): __________________________________

Office use only

Clinic site: _____________________________

NPP given ❑ yes ❑ No Date: / /

MRN #: ________________

Documented in CPM ❑ yes ❑ No

Label