

# Adventist Health Patient Registration Form

(Please give your insurance card to the receptionist)

**Office Use Only:** NPP Given:      Yes      No      Effective Date:

Name: Last, First, Middle		Sex    M F	Marital Status M    D    LS    Unk S    W    DP		Ethnicity
Home Address: City, State, Zip Code			Preferred Language		
DOB	Social Security Number		Home Phone	Cell Phone	
Reason for today's visit:			How did you hear about us?		
<b>Do you have Medicare?</b> Yes      No			<b>Do you have Medi-Cal?</b> Yes      No		

Primary Care Physician:

Do you want to join the PATIENT PORTAL?      YES      NO      If yes, please provide us:

E-mail address:      and the last 4 digits of your SS #:

Challenge Question Answer; will be the last 4 digits of your social security number.

You will receive an E-mail invite soon.

**Subscriber Information**

Subscriber Name	Relationship to Patient		Subscriber DOB
Subscriber SS #	Home Phone		Cell Phone
Address (if different than above)	City	State	Zip Code

**Minor / Guarantor's Information**

Name of responsible party	Relationship to Patient		Best Phone Number
Responsible parties SS #	Responsible parties DOB		
Address (if different than above)	City	State	Zip Code

In case of emergency person to contact:	Relationship to Patient		Home Phone
Address (if different than above)	Can we discuss PHI with this person?    Yes    No		Cell Phone

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

Signature of Patient / Parent / Legal Guardian / Custodian	Date	Time
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