Adventist Health Physicians Network

# 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? | |
| **Do you have Medicare?** ☐ **Yes** ☐ **No** | | **Do you have Medi-Cal?** ☐ **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 |