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