advocare

Adult Registration Form

☐ New Patient ☐ Edit Information

*****For All Patients over 18 years of Age *****

Please complete this form to ensure proper billing of your services. **Please Print.** Today's Date: _____

Patient Information

Please provide Photo ID.

Patient Last Name: _____
First Name: _____ MI: _____
Preferred Name: _____
Date of Birth: _____ SS#: _____
Address: _____
City, State, Zip: _____
Home Phone: (_____) _____
Cell Phone: (_____) _____
Work Phone: (_____) _____

Gender:
☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F
☐ Decline to specify

Marital Status:
☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
☐ Life Partner ☐ Significant Other
☐ Other: _____

Student Status:
☐ Full-time ☐ Part-time ☐ N/A

Ethnicity:
☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Declined to specify

Race:
☐ American Indian/Alaska Native ☐ Asian
☐ African American ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Declined to specify

Preferred Language:
☐ English ☐ Spanish
☐ Other: _____

Translator?
☐ YES ☐ NO

Comments: _____
_____

Provider Information

Complete this section if applicable.

Primary Care Provider:
Name: _____
Address: _____
_____
City, State, Zip: _____
Phone: _____
Fax: _____

Referring Provider:
Name: _____
Address: _____
_____
City, State, Zip: _____
Phone: _____
Fax: _____

Patient's Reminders/Communication

This section is related to communication and Patient Portal access. (See 'Patient Portal FAQs')

Due to HIPAA regulations all patients over 18 must use their own information unless a legal guardian/court document is supplied.

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

☐ Web Enabled E-Mail: _____
☐ No Email ☐ Patient Refused *(must be patient's email, not Proxy)*

☐ Voice Enabled Messaging ☐ English ☐ Spanish **Preferred method:** ☐ Home ☐ Cell ☐ Work
☐ Text Enabled Messaging ☐ English ☐ Spanish **Preferred method:** ☐ Home ☐ Cell ☐ Work

Types of reminders you wish to receive:
☐ Appointments ☐ Lab results ☐ Health Maintenance ☐ RX Confirmation ☐ General ☐ **ALL** ☐ **NONE**

Patient's Employment Information

Emp. Status:
☐ Employed FT ☐ Employed PT ☐ Not Employed ☐ Self ☐ Active Military ☐ Retired ☐ Reserved for Nat'l assignment

Employer: _____ Occupation: _____

Preferred Pharmacy Information

Primary Pharmacy Name, Address & Phone #: _____

_____

Patient's Emergency Contact

Last Name, First Name: _____ Patient's Relationship to Contact: _____

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Insurance Information

Please provide a copy of ALL Insurance cards.

Please let us know if this is a ☐ Worker's Comp Issue ☐ MVA ☐ Legal Case ☐ School Insurance

☐ Self-Pay (no insurance)
☐ Medicaid – ID Number: _____

Patient relationship to Insured:
☐ Self ☐ Spouse ☐ Child ☐ Other: _____

PRIMARY INSURANCE NAME:

Benefit Plan Name: _____

Member ID: _____

Group#: _____ Effective Date: _____

Subscriber's Name: _____

Subscriber's DOB: _____

Gender:
☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F
☐ Decline to specify

PCP listed on Card: _____

SECONDARY INSURANCE NAME:

Benefit Plan Name: _____

Member ID: _____

Group#: _____ Effective Date: _____

Subscriber's Name: _____

Subscriber's DOB: _____

Gender:
☐ M ☐ F ☐ Transgender ☐ Neither exclusively M or F
☐ Decline to specify

PCP listed on Card: _____

I have completed this form to the best of my knowledge and I understand I am to contact the office with changes to my personal information. I understand that I am responsible for all outstanding patient liabilities and financial obligations.

Patient Name: _____ *Date:* _____

Patient Signature: _____

If Patient has a Legal Guardian, a copy of the legal document granting you such power must be attached or on file with Advocare LLC.