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#: _____

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: _____

Primary Care Provider:

Name: _____

Address: _____

_____

City, State, Zip: _____

Phone: _____

Fax: _____

Referring Provider:

Name: _____

Address: _____

_____

City, State, Zip: _____

Phone: _____

Fax: _____

Patient's Primary Address

Address: _____

City, State, Zip: _____

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

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.