PATIENT REGISTRATION

AccelHealth

PATIENT

LAST NAME	FIRST NAME	MIDDLE NAME

SOCIAL SECURITY NUMBER	AGE	DATE OF BIRTH

MAILING ADDRESS	APT NO

CITY	STATE	ZIP	COUNTY

Please answer the following questions so we may better serve you:

In the last 2 years have you or anyone in your family worked in any type of agriculture (farm work) like: planting, picking, preparing the soil, packing house, driving a truck for any type of farm work, worked with animals? ☐ YES ☐ NO

In the last 2 years, have you or a member of your family lived away from home in order to work in any type of agriculture? ☐ YES ☐ NO

Have you or a family member stopped migrating to work in agriculture because of a disability? ☐ YES ☐ NO

HOME PHONE	WORK PHONE	CELL PHONE	Emergency Contact
			Name: Phone:

BIRTH SEX: ☐ MALE ☐ FEMALE

CURRENT GENDER: ☐ MALE ☐ FEMALE ☐ UNDIFFERENTIATED

GENDER IDENTITY (THIS SECTION IS OPTIONAL FOR PATIENTS UNDER 18)
☐ MALE ☐ FEMALE ☐ TRANSGENDER MALE/FEMALE-TO-MALE(FTM)/TRANS MAN
☐ TRANSGENDER FEMALE/MALE-TO-FEMALE(MTF)/TRANS WOMAN
☐ GENDERQUEER- NEITHER MALE NOR FEMALE ☐ OTHER ☐ CHOOSE NOT TO ANSWER

SEXUAL ORIENTATION (OPTIONAL FOR PATIENTS UNDER 18)
☐ STRAIGHT OR HETEROSEXUAL
☐ LESBIAN, GAY, OR HOMOSEXUAL
☐ BISEXUAL
☐ SOMETHING ELSE
☐ CHOOSE NOT TO ANSWER ☐ DON'T KNOW

RACE (MAY SELECT MORE THAN ONE):
☐ AMERICAN INDIAN OR ALASKA NATIVE
☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ WHITE ☐ CHOOSE NOT TO ANSWER

PREFERRED PRONOUN:
☐ HE, HIM, HIS ☐ OTHER
☐ SHE, HER, HERS ☐ ZE, HIR
☐ THEY, THEM, THEIRS
☐ DECLINE TO ANSWER

ETHNICITY:
☐ HISPANIC OR LATINO
☐ NOT HISPANIC OR LATINO
☐ CHOOSE NOT TO ANSWER
☐ OTHER
☐ UNKNOWN

PREFERRED LANGUAGE:
☐ English
☐ Spanish
☐ Other:_____

MARITAL STATUS:
☐ MARRIED
☐ SINGLE
☐ DIVORCED/SEPARATED
☐ WIDOWED

Are you a US Veteran? ☐ YES ☐ NO

Homeless Status:
☐ Not Homeless ☐ Doubling Up
☐ Shelter ☐ Street
☐ Transitional ☐ Other

How did you hear about AccelHealth?
☐ Billboard ☐ Newspaper
☐ Event Sponsor ☐ Publication
☐ Friend/Family ☐ Radio
☐ Insurance ☐ Social Media
☐ Internet ☐ Other

PRIMARY INSURANCE NAME
Please give card to staff

SECONDARY INSURANCE NAME
Please give card to staff

May we leave detailed phone messages? ☐ Yes ☐ No
May we mail detailed correspondence to your address? ☐ Yes ☐ No
May we text you important reminders? ☐ Yes ☐ No
May we email you information? ☐ Yes ☐ No
Email address:

COMPLETE THIS SECTION ONLY IF PATIENT IS A MINOR (NOT APPLICABLE FOR FAMILY PLANNING SERVICES)

PARENTS

PARENT / GUARDIAN #1		PARENT / GUARDIAN #2	
MAILING ADDRESS ☐ CHECK IF SAME AS ABOVE		MAILING ADDRESS ☐ CHECK IF SAME AS ABOVE	
CITY/STATE/ZIP		CITY/STATE/ZIP	
DATE OF BIRTH	HOME PHONE	DATE OF BIRTH	HOME PHONE
WORK PHONE	CELL PHONE	WORK PHONE	CELL PHONE
SOCIAL SECURITY NUMBER	EMPLOYER	SOCIAL SECURITY NUMBER	EMPLOYER
RELATIONSHIP TO CHILD: ☐ MOTHER ☐ FATHER ☐ GRANDPARENT ☐ FOSTER PARENT ☐ OTHER _____		RELATIONSHIP TO CHILD: ☐ MOTHER ☐ FATHER ☐ GRANDPARENT ☐ FOSTER PARENT ☐ OTHER _____	

RELEASE OF INFORMATION/FINANCIAL RESPONSIBILITY

I hereby authorize AccelHealth to release any medical or other information needed to process all insurance claims. I authorize payment of insurance benefits directly to AccelHealth. I agree that I am responsible for payments for services rendered, deductibles and coinsurance. I am aware that failure to pay may result in termination of the patient/clinic relationship. A photocopy of this authorization shall be considered as valid as the original. This authorization will remain in effect until revoked by me in writing.

By signing this form, I am saying that I understand what is written above and that I voluntarily ask for and consent to treatment.

PATIENT OR AUTHORIZED SIGNATURE	*DATE*