UCSF Benioff Children's Physicians

Adult Patient Registration Form

*Instructions: Please complete **all applicable fields** below.*

Patient Information

Patient Name (Last, First):		**Date of Birth (DOB):**
Marital Status:	**Sex:**	**SSN:**
Home Address:		
Home Phone #:	**Cell Phone #:**	
Email Address:		
What is your preferred language?	**Would you like an interpreter?** ☐ Yes ☐ No	
How would you like to receive appointment reminders? ☐ Text Message ☐ Phone Call ☐ Do Not Remind	**Are you currently employed?** ☐ Yes ☐ No If yes, **Employer Name**: **Employment Status:** ☐ Full Time ☐ Part Time	
Name of Primary Care Provider (PCP):		

Emergency Contacts

In **case of an emergency**, please provide the names of **individuals** (e.g. spouse or friend) we should contact below:

(1) Emergency Contact Name:	
Is this emergency contact's address **the same** as the patient's address? ☐ Yes ☐ No	
*If no, please **enter address** here:*	
Home and/or Cell Phone #:	**Relationship to Patient:** ☐ Mother/Father ☐ Spouse ☐ Significant Other ☐ Aunt/Uncle ☐ Brother/Sister ☐ Other Relative ☐ Caregiver ☐ Friend
(2) Emergency Contact Name:	
Is this emergency contact's address **the same** as the patient's address? ☐ Yes ☐ No	
*If no, please **enter address** here:*	
Home and/or Cell Phone #:	**Relationship to Patient:** ☐ Mother/Father ☐ Spouse ☐ Significant Other ☐ Aunt/Uncle ☐ Brother/Sister ☐ Other Relative ☐ Caregiver ☐ Friend

Primary Insurance Information

Name of primary health insurance coverage plan:	
Policy ID #:	**Group #:**

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Who is the primary subscriber of the plan? ☐ Me ☐ (1) Emergency Contact ☐ (2) Emergency Contact ☐ Someone Else		
If 'Someone Else' please provide their **name and address**:		
Relationship to Patient: ☐ Mother/Father ☐ Spouse ☐ Significant Other ☐ Other Relative		
Home and/or Cell Phone #:	Is the **subscriber** currently employed? ☐ Yes ☐ No	
Subscriber's Employer Name:	☐ Full Time ☐ Part Time ☐ Retired	
Subscriber's DOB:	**Sex:**	**SSN:**

Secondary Insurance Information

Name of secondary health insurance coverage plan:		
Policy ID #:	**Group #:**	
Who is the primary subscriber of the secondary plan? ☐ Me ☐ (1) Emergency Contact ☐ (2) Emergency Contact ☐ Someone Else		
If 'Someone Else' please provide their **name and address**:		
Relationship to Patient: ☐ Mother/Father ☐ Spouse ☐ Significant Other ☐ Other Relative		
Home and/or Cell Phone #:	Is the **subscriber** currently employed? ☐ Yes ☐ No	
Subscriber's Employer Name:	☐ Full Time ☐ Part Time ☐ Retired	
Subscriber's DOB:	**Sex:**	**SSN:**

How Did You Hear About Us?

☐ Family/Friend ☐ Referring Provider ☐ Internet/TV/Radio ☐ Health Insurance Provider ☐ Not Sure

Name of Referring Provider:	
If pregnant, what is your **Expected Due Date (EDD)?**	☐ Singleton ☐ Twins ☐ Multiples

What is the Name and Address of Your Preferred Pharmacy and Lab?

Patient Signature:	**Today's Date:**

Thank you! Please hand this form back to the registration staff at the front desk.

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Detailed Messages Regarding Healthcare Information Form

You have the right to authorize UCSF Benioff Children's Physicians (UBCP) providers and staff to leave detailed voice messages regarding your health information on an answering machine or other voice recording system. If you authorize UBCP providers and staff to leave detailed voice messages this authorization entitles; hospitals, provider offices, home health, etc. to leave detailed information, which may include medical diagnosis, surgical information, other healthcare services, test results, medication information and treatment of any illness or condition. Detailed message authorization is optional and not a requirement. UBCP will only leave detailed messages regarding health information for the phone number authorized below and will not leave detailed messages at any other numbers in the record. The authorization to leave detailed voice messages will remain valid until withdrawn in writing, unless specified by a calendar date. **There are risks associated with leaving detailed voice messages regarding your health information, including, but not limited to, potential disclosure to a third-party. By signing this authorization form you acknowledge and accept the risks associated with this type of release. If your health information is disclosed to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.**

Additionally, you have the right to authorize UCSF Benioff Children's Physicians (UBCP) providers and staff to discuss your detailed medical information with designated individuals. Such detailed information may include medical diagnosis, surgical information, other healthcare services, test results, medication information and treatment of any illness or condition. This authorization is optional and not a requirement. The authorization to discuss your detailed medical information with designated individuals will remain valid until withdrawn in writing, unless specified by a calendar date. Please complete the UBCP Authorization for Release of Health Information Form to authorize designated individuals.

Patient Information	
Patient Name (Last, First):	
Date of Birth (DOB):	**Medical Record Number (MRN):**

Today's Date (Date of Authorization):

Phone Number(s) Authorized for Detailed Messages	
Phone Number	**Type**
	☐ Home ☐ Cell ☐ Work
	☐ Home ☐ Cell ☐ Work
	☐ Home ☐ Cell ☐ Work

Specific Date(s) (Optional)	
From:	To:

Signature of Patient or Witness (required if patient unable to sign) **Today's Date**

Witness Relationship to Patient

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We Ask Because We Care

Please complete this questionnaire. We use this information to review the treatment patients receive and to ensure that everyone gets the highest quality of care. Your individual responses are private and will not be shared outside the health care system.

1. Do you consider yourself Hispanic/Latino? ☐ Yes ☐ No ☐ Decline to answer

2. How would you describe your Race? By race, we mean the major world group or groups from which your ancestors came. *Please check as many categories as you need to describe yourself.*

☐ American Indian/Alaska Native
☐ African American/Black
☐ Native Hawaiian/Other Pacific Islander
☐ Asian
☐ White
☐ Decline to Answer
☐ Other_____

3. How would you describe your Ethnicity? By ethnicity, we mean the group or groups with whom you share your cultural identity or customs. *Please check as many categories as you need to describe yourself.*

☐ African
☐ African American/Black
☐ Alaska Native
☐ American Indian
☐ Arab/North African
☐ Asian Indian
☐ Cambodian
☐ First Nation (Canada)
☐ Caribbean/West Indian
☐ Central American
☐ Chinese
☐ European/European Descent
☐ Filipino
☐ Guamanian
☐ Hmong
☐ Indigena - Maya
☐ Japanese
☐ Korean
☐ Laotian
☐ Mexican
☐ Middle Eastern
☐ Mongolian
☐ Native Hawaiian
☐ Pacific Islander
☐ Russian
☐ Samoan/American Samoan
☐ South American
☐ Thai
☐ Tibetan
☐ Tongan
☐ Vietnamese

☐ Decline to Answer ☐ Other_____

4. In which state and/or country were you born?_____

Please hand this form back to the front desk staff when completed. Thank you.