Primary Care Partners
Affiliated with Atlantic Health System

Child/Dependent Registration Form

☐ New Patient ☐ Edit Information

Today's Date: _____

Patient Information

Patient Last Name: _____

First Name: _____ MI _____ Date of Birth: _____

Sex: ☐ M ☐ F ☐ Nonbinary ☐ Other ☐ Unknown ☐ X

Sex Assigned at Birth: ☐ M ☐ F ☐ Uncertain ☐ Unknown
☐ Choose not to disclose
☐ Not Recorded on Birth Certificate

Gender Identity: ☐ M ☐ F ☐ Other
☐ Transgender Female/Male-to-Female
☐ Transgender Male/Female-to-Male
☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Hearing Impaired? ☐ YES ☐ NO Comments: _____
Vision Impaired? ☐ YES ☐ NO Comments: _____

Sexual Orientation: ☐ Bisexual ☐ Choose not to disclose ☐ Don't know
☐ Lesbian or Gay ☐ Something Else
☐ Straight (Not Lesbian or Gay)

Ethnicity: (Data is used for statistical reporting.)
☐ Central/S Am ☐ Cuban ☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Mexican ☐ Puerto Rican ☐ Rather Not Say ☐ Other _____
Religion: _____

Race: (Data is used for statistical reporting.)
☐ American Indian ☐ Asian ☐ African American ☐ White
☐ Native Hawaiian/Pacific Islander ☐ Unknown ☐ Rather Not Say

Patient's Primary Address

Address: _____

City, State, Zip: _____

County: _____

Country: _____

Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work
☐ Alt Phone ☐ Letter ☐ Email
Automated Reminder Calls/Text about Appointment ☐ YES ☐ NO

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

E-Mail: _____ ☐ No Email ☐ Patient refused

Patient's Parental Information

Patient lives with ☐ Both Parents ☐ Mom ☐ Dad ☐ Guardian ☐ Other (please explain: _____)
Custody Agreement ☐ YES ☐ NO ☐ N/A (If YES, please provide copy)

Parent's Name: _____
Parent Address same as patient ☐ YES ☐ NO

If NO- please complete
Addr1: _____
Addr2: _____
City, State, Zip: _____

Home phone: _____
Cell Phone: _____
Email Address: _____
Preferred Method of Contact:
☐ Alt Phone Number ☐ Email ☐ Letter
☐ Phone Call (Cell) ☐ Phone Call (Home

Employment Status:
☐ Employed FT ☐ Employed PT ☐ Homemaker ☐ Disabled
☐ Unemployed ☐ Active Military ☐ Retired ☐ Other

Employer: _____

Parent's Name: _____
Parent Address same as patient ☐ YES ☐ NO

If NO- please complete
Addr1: _____
Addr2: _____
City, State, Zip: _____

Home phone: _____
Cell Phone: _____
Email Address: _____
Preferred Method of Contact:
☐ Alt Phone Number ☐ Email ☐ Letter
☐ Phone Call (Cell) ☐ Phone Call (Home)

Employment Status:
☐ Employed FT ☐ Employed PT ☐ Homemaker ☐ Disabled
☐ Unemployed ☐ Active Military ☐ Retired ☐ Other

Employer: _____

Pharmacy Name, Address & Phone #: _____

Insurance Information – *Please provide a copy of the card*

PRIMARY CARRIER: _____ Telephone #: (_____) _____

Address: _____ Child's ID: _____

Subscriber's Name: _____ Group/Plan#: _____ Effective Date: _____

Subscriber's DOB: _____ Sex: ☐ M ☐ F ☐ Other

Patient Relationship to Insured: _____ PCP listed on Card: _____

Guarantor Information *(Guarantor is the person financially responsible for this patient's bill.)*

Guarantor: _____ Patient's Relationship to Guarantor: _____

Addr1: _____

Addr2: _____ Date of Birth: _____ Sex: ☐ M ☐ F ☐ Other

City, State, Zip: _____ Home Phone: (_____) _____

Employer: _____ Work Phone: (_____) _____

Address: _____ Cell Phone: (_____) _____

City, State, Zip: _____ Email Address: _____

Emergency Contact Information (Someone living outside the primary household)

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

Addr1: _____ Home Phone: (_____) _____

Addr2: _____ Work Phone: (_____) _____

City, State, Zip: _____ Cell Phone: (_____) _____

Assignment of Benefits/Authorization/Notice of Collection Action

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at time of service and I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs). Also, please be advised our office may contact you via an automated system regarding appointments and/or account status. I agree this authorization shall remain valid unless/until I rescind in writing. (Please see the Primary Care Partners Payment Policy and Notice of Privacy Practices for more information)

Signature_____ Print Name_____Date_____

_____ _____

(Guarantor/Legal Guardian Signature) (Guarantor/Legal Guardian Print Name)