Primary Care Partners
Affiliated with Atlantic Health System

Adult Registration Form

☐ New Patient ☐ Edit Information

Today's Date: ______________________

Please complete this form in order to ensure proper billing of your services. **Please Print.**

Patient Information- *Please provide Photo ID*

Patient Last Name: ________________________________ Social Security Number: ______________________

First Name: ______________________ MI ________ Date of Birth: ____________________

Alias/Preferred Name: ________________________________

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

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: ____________

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

Hearing Impaired? ☐ YES ☐ NO Comments: ______________

Vision Impaired? ☐ YES ☐ NO Comments: ______________

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 Contact Information

Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work ☐ Alt Phone ☐ Letter ☐ Email

Automated Reminder Calls/Text about Appointment ☐ YES ☐ NO

E-Mail: ________________________________ ☐ No Email

Home Phone: (__________) ____________________

Cell Phone: (__________) ____________________

Work Phone: (__________) ____________________

Alt Phone: (__________) ____________________

Patient's Primary Address

Address: ________________________________ City, State, Zip: ______________________________

County: ________________________________ Country: ______________________________

Patient's Employment Information

Emp. Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Disabled ☐ Student ☐ Active Military ☐ Self-Employed ☐ Other __________

Employer: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

County: ____________________ Country: __________

Patient's Emergency Contact

Emergency Contact Name.: ________________________________ Home Phone: (________) ____________________

Patient's Relationship to Emerg. Cont.: ____________________________ Cell Phone: (________) ____________________

Pharmacy Name, Address & Phone #: ____

INSURANCE INFORMATION – *Please provide copies of all cards*

(A separate form is required for worker's compensation, automobile liability, or legal services.)

PRIMARY CARRRIER: ______________________________ Telephone #: (________) ______________________

Address: ______________________________ ID/Cert #: ______________________

Group/Plan #: ______________ Effective Date: ______________ Subscriber's Name: ______________________

Subscriber's DOB: _____ SSN: ______________ Sex: ☐ M ☐ F ☐ Other Relationship to Patient: ______________________

SECONDARY CARRIER: ______________________________ Telephone #: (________) ______________________

Address: ______________________________ ID/Cert #: ______________________

Group/Plan #: ______________ Effective Date: ______________ Subscriber's Name: ______________________

Subscriber's DOB: _____ SSN: ______________ Sex: ☐ M ☐ F ☐ Other Relationship to Patient: ______________________

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

Please complete if guarantor is other than self

Guarantor: ______________________________ Patient's Relationship to Guarantor: ______________

Addr: ______________________________ Social Security Number: ______________________

City, State, Zip: ______________________________ Date of Birth: ______________________

County: ______________ Country: ______________ Sex: ☐ M ☐ F ☐ Other

Home Phone: (________) ______________________ Cell Phone: (________) ______________________

(Billing company utilizes TEXTING)

Guarantor's Employer: ______________________________ Work Phone: (________) ______________________

Address: ____

City, State, Zip: ____

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______________________

Please complete this section if the patient is covered by Medicare

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed? ☐ YES ☐ NO

Do you or your spouse have other insurance? ☐ YES ☐ NO

Are you disabled or have end stage renal disease? ☐ YES ☐ NO

Is illness/injury the result of an auto accident? ☐ YES ☐ NO

Has treatment been authorized by the V.A.? ☐ YES ☐ NO

Are you covered under the Black Lung Program? ☐ YES ☐ NO

Is there Medigap coverage secondary to Medicare? ☐ YES ☐ NO

Is there insurance coverage primary to Medicare? ☐ YES ☐ NO

Is there employer supplemental coverage secondary to Medicare? ☐ YES ☐ NO

The undersigned certifies that the questions have been answered truthfully and hereby authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services

Signature______________________ Print Name______________________ Date______________________