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

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

E-Mail: _____ ☐ No Email

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	Has treatment been authorized by the V.A.?	☐ YES ☐ NO
Do you or your spouse have other insurance?	☐ YES ☐ NO	Are you covered under the Black Lung Program?	☐ YES ☐ NO
Are you disabled or have end stage renal disease?	☐ YES ☐ NO	Is there Medigap coverage secondary to Medicare?	☐ YES ☐ NO
Is illness/injury the result of an auto accident?	☐ 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_____