



# Primary Care Partners

Affiliated with  
Atlantic Health System

## Child/Dependent Registration Form

New Patient  Edit Information

Today's Date: \_\_\_\_\_

### Patient Information

Patient Last Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

First Name: \_\_\_\_\_ MI \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex:  M  F  Nonbinary  Other  Unknown  X

Gender Identity:  M  F  Other

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

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 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  
Custody Agreement  YES  NO  N/A (If YES, please provide copy)

Other (please explain: \_\_\_\_\_)

Parent's Name: \_\_\_\_\_

Parent Address same as patient  YES  NO

Parent's Name: \_\_\_\_\_

Parent Address same as patient  YES  NO

If NO- please complete

Addr1: \_\_\_\_\_

Addr2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

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)

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

Employment Status:

Employed FT  Employed PT  Homemaker  Disabled

Unemployed  Active Military  Retired  Other

Employer: \_\_\_\_\_

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  
Subscriber SS#: \_\_\_\_\_  
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: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
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)



# CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, INCLUDING ADMISSION AND MEDICAL TREATMENT AUTHORIZATION

This form cannot be modified. Any handwritten changes to this form shall not be legally binding or enforceable.

**GENERAL CONSENT; AUTHORIZATION, PATIENT RIGHTS AND RESPONSIBILITIES, PATIENT CONTACT**

I authorize Atlantic Health System (which includes CentraState, Chilton, Hackettstown, Morristown, Newton and Overlook Medical Centers, collectively referred to as "Hospital"), Atlantic Medical Group ("AMG"), Atlantic Affiliates, Hospital staff, AMG staff and the physician(s) participating in my care to render hospital and medical care for my condition, which may include routine diagnostic procedures and such other medical treatment as may be deemed advisable by the physician(s) participating in my care. This may or may not include admission to the Hospital. I acknowledge that no guarantees have been made to me about the outcome of my medical care and treatment. I understand and acknowledge that the majority of the physicians at the Hospital are members of the Voluntary Medical Staff and are not employees or agents of the Hospital, but are either independent contractors or independent practitioners who have been granted the privilege of using the Hospital's facilities for the care and treatment of their patients. This includes, but is not limited to: Emergency Department physicians, anesthesiologists, cardiologists, neonatologists, obstetricians, pathologists, radiologists, surgeons, the on call physician, telehealth providers, and other consultants who may treat me. I understand that telehealth involves the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services. I consent to treatment and care by Hospital affiliates and by their physicians and health care providers, including those who are located at sites other than the one at which I am present and who provide treatment and care through telehealth. I understand that physicians in training, medical and nursing students, and paramedical personnel may observe and participate in my care under the supervision of the Hospital or AMG staff and my physician(s). I authorize the Hospital to arrange for the disposition of all specimens and tissues. These consents and authorizations shall also apply to the admission and medical treatment of a newborn infant who is delivered by me during my hospitalization. I understand that it may be necessary for my healthcare provider(s) to take photographs, films, recordings and/or other like images and that the presence of a vendor representative may be required for medical, educational and/or continuity of care purposes.

I hereby acknowledge receipt of a Statement of Patient Rights and Responsibilities. I understand that professional personnel are available to explain the Statement upon request.

The Hospital maintains a current list of patients and their location in the hospital.  I hereby permit my location to be provided to friends, family and/or visitors.

I authorize Hospital, AMG and Atlantic Affiliates, all clinical providers who have provided care to me, and their authorized agents, including but not limited to any billing services, collection agencies, attorneys or other agents who may work on their behalf, to contact me via electronic mail, text and/or telephone on my cell phone and/or home phone using automatic telephone dialing systems or other computer assisted technology.  I hereby authorize such contact at this time.

**FINANCIAL ARRANGEMENTS**

I understand the Hospital charges do not include the fees of my treating physician or the fees for services provided by other Voluntary Medical Staff who may treat me. I understand that I am financially responsible for the payment of my physician fees and my hospital bill; these fees may not be covered by my insurance plan. I authorize payment of medical insurance benefits (including managed care, Medicare and Medicaid, when applicable) directly to the Hospital and/or any physician(s) participating in my care. I understand that some insurance and managed care entities require pre-approval of certain hospitalizations, procedures and surgeries, and it may be my responsibility to obtain appropriate pre-approvals. If I am receiving hospital billed services, a copy of "An Important Message from Medicare" or "An Important Message from TRICARE", as applicable, and "Notice of Charity Care and Reduced Charity Care" have been made available to me. I understand my rights as outlined in the document(s) I have received. A deposit may be requested. If I am a Medicaid beneficiary, I certify that I am receiving the services covered by this consent and I request that payment for these services be made. Not applicable to Emergency Department Treatment Authorization.

**PROTECTED HEALTH INFORMATION**

I have received a copy of the Notice of Privacy Practices for Protected Health Information (the "Notice"). The Notice provides a complete description of the uses and disclosures of my Personal Protected Health Information ("PHI"). I have had an opportunity to review this information before signing this form. I consent to the Hospital, Atlantic Affiliates, AMG and/or any physician(s) participating in my care releasing my PHI (either in writing or verbally) in order to carry out treatment, payment, or health care operations. This includes any medical information (including drug and alcohol abuse treatment information, psychiatric treatment information, and HIV related information including HIV testing results (if applicable), which may be needed to process claims for medical insurance (or managed care) benefits relative to this hospitalization (including precertification or verification, if necessary), or which may be needed to conduct continued care planning, which may include release of my PHI to home healthcare agencies.

**AUTHORIZATION TO DRAW BLOOD**

In the event that any individual participating in my care is accidentally exposed to my blood or bodily fluids, I authorize the Hospital to draw my blood and test it for the presence of blood borne pathogens such as the Human Immunodeficiency Virus ("HIV"). I understand that if such testing is necessary the Hospital or my physician will make all reasonable efforts to notify me. I consent to the confidential disclosure of the test results to the authorized medical provider treating the person who has been exposed to my blood or bodily fluids, so that appropriate treatment determinations may be made. I understand that I do not have to agree to testing and/or disclosure of my test results.

By initialing here I agree to be tested for blood borne pathogens such as the Human Immunodeficiency Virus ("HIV") and I consent to the disclosure of my blood test results.

**VALUABLES**

I understand that the Hospital recommends all personal belongings and valuables be sent home with a family member or friend. I assume all risk for loss or damage to any personal belongings retained by me. The Hospital will not replace or reimburse me for any personal belongings which are lost, broken or stolen during my admission.

**OUTPATIENT SERVICES IN HOSPITAL SETTING**

I understand that I am having care, testing, procedure(s) or treatment that is considered an outpatient procedure in a hospital setting. As such, there may be different requirements for deductibles and/or copays than for a physician office visit. I understand that it is my responsibility to fully understand the requirements of my insurance company or managed care entity and that I am responsible for payment of any copayments, deductibles, and charges as required. If the services rendered qualify me for recurring status, my signature on this consent shall be valid for care rendered throughout this period.

(Initial) I understand that there will be two components to my bill: the professional services provided by my physician and the tests and/or procedures conducted by the Hospital.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR PERSON SIGNING / CONSENTING ON BEHALF OF PATIENT Date \_\_\_\_\_ Time \_\_\_\_\_ (am) (pm)

If I am signing / consenting on behalf of the patient, I recognize that signing / consenting on behalf of the patient is not an acceptance of financial responsibility which I would not otherwise have for the services rendered.

\_\_\_\_\_  
PRINTED NAME OF PERSON SIGNING/CONSENTING ON BEHALF OF PATIENT Relationship \_\_\_\_\_

For verbal consents, print full name of employee witness: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ (am) (pm)

For verbal consents, print full name of employee witness: \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ (am) (pm)

PATIENT UNABLE TO SIGN BECAUSE: \_\_\_\_\_



## PATIENT/FAMILY CONTACT LIST

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Contacts**

People who have permission to receive detailed information about your care (PHI):

**PRIMARY CONTACT**

Name: _____	Phone Numbers
	Cell: _____
Relationship: _____	Home: _____
<input type="checkbox"/> Check here if you would like us to involve this person in discussions about your health care	Other: _____

**SECONDARY CONTACT(S)**

Name: _____	Phone Numbers
	Cell: _____
Relationship: _____	Home: _____
<input type="checkbox"/> Check here if you would like us to involve this person in discussions about your health care	Other: _____

Name: _____	Phone Numbers
	Cell: _____
Relationship: _____	Home: _____
<input type="checkbox"/> Check here if you would like us to involve this person in discussions about your health care	Other: _____

I decline to designate a representative at this time.

Comments/Other Information:

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This form is effective upon execution and will remain in effect unless revoked by me.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_



# Primary Care Partners

Affiliated with  
Atlantic Health System

Care Center Name: \_\_\_\_\_

## Authorization to Bring a Minor

This authorization form is to be used when someone other than the parent or legal guardian will be bringing a minor to the physician's office.

Please check off all that apply

Child's Name	Date of Birth	Evaluation	Treatment	Admin of Vaccines

I hereby provide permission for the following person to bring my child(ren) to the office for the services that I have checked off above.

Name	Relationship to Child (ren)	Expiration Date

I understand that when the person(s) identified above take my child to Primary Care Partners, \_\_\_\_\_ (Care Center Name) for a medical problem, my child(ren)'s protected health information that the medical provider determines relevant to the office visit may be disclosed to this person.

I understand that when the person(s) identified above takes my child(ren) for a well visit or for treatment of a medical problem, that this person may need to consent for my child(ren) to receive medical services that the medical provider determines necessary for the care and treatment of my child(ren). I hereby authorize the person(s) listed above to provide consent for the provision of the medical services stated above to my child(ren) by the Medical Providers of Primary Care Partners, \_\_\_\_\_ (Care Center Name).

\_\_\_\_\_  
Name of Parent/Legal Guardian

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Child(ren)

\_\_\_\_\_  
Date

**This authorization shall be valid for each visit that the person(s) identified above takes your child(ren) to Primary Care Partners, \_\_\_\_\_, office unless you provide an expiration date OR written notice of revoking authorization to the Primary Care Partners Care Center list above.**

Initials

## Vaccine Policy Statement

- We, the physicians of Primary Care Partners, believe in the safety and the effectiveness of vaccines to prevent serious illness and save lives.
- We firmly believe that both children and adults should receive all the recommended vaccines.
- We firmly believe, based on all available evidence from peer reviewed medical studies, that vaccine are *not* the cause of developmental disabilities nor autism spectrum disorders.
- We firmly believe that vaccinating children and adults is among the most important preventive measures we can take for overall health and well-being. The recommended vaccinations and vaccine schedule are the result of an enormous volume of scientific study and data gathered over many decades. This information has undergone rigorous review, in the United States as well as around the globe, by experts who are the most educated and informed on the subject.
- In recent years there has been a re-emergence of many vaccine-preventable diseases. It is most often the unvaccinated individuals in the community, both children and adults, that serve as the primary reservoir for spread.
- Not all adults or children are able to receive all vaccines, and some may not be able to mount the appropriate immune response to a vaccine, leaving them vulnerable. Reasons for this may include age as well as medical conditions. We believe it is our responsibility to consider these friends and family members and provide them protection by becoming vaccinated ourselves.
- We provide this education to emphasize the importance of vaccinations. If you have questions or concerns about vaccines, please discuss them with your healthcare provider. They are reliable and accurate sources of information and can direct you to further accurate and reliable information regarding the vaccine schedule and each vaccine.
- Any changes to the recommended vaccine schedule would need to be agreed to by you and your healthcare provider. Please be advised, however, that delaying or deviating from the recommended schedule for vaccines goes against expert recommendations, can put your child at risk for serious illness or death, and goes against our advice as extensively trained medical providers. There are no studies available on schedules that deviate from the approved schedule to demonstrate equivalent efficacy or protection.
- As medical professionals, it is our goal to keep each one of our patients safe and healthy. We feel strongly that vaccinating on schedule is the right decision to

protect all children and adults. Please recognize that by not vaccinating yourself or your child you are at unnecessary risk for life-threatening illness, disability, or death.

- COVID Vaccine- Covid vaccines are not currently mandated by the State of NJ and will not be required until they are mandatory.
- It is our policy to have all our patients follow the recommended vaccine schedule.
- If vaccines are already drawn up after parents have discussed with the provider a particular vaccine to be administered and the parent changes their mind, they are then responsible for the cost of the vaccine (not the admin fee). The child will then need to come back when they are ready for the vaccine to be administered. This vaccine will go through the insurance to be paid.
- If you choose not to vaccinate your child in the recommended manner, we may ask you to find another primary care physician and will assist you in the process.

10/29/2025



**Primary Care Partners**

Aligned with  
**Atlantic Health System**  
**Skylands Pediatrics**

I, \_\_\_\_\_, have received a copy of the

**Skylands Pediatrics vaccine policy.**

**Child/Children's name(s):**

\_\_\_\_\_ **DOB:** \_\_\_\_\_

\_\_\_\_\_ **DOB:** \_\_\_\_\_

\_\_\_\_\_ **DOB:** \_\_\_\_\_

**Signature Parent/Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Signature of Witness:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Will be vaccinating**

**Will NOT be vaccinating**

