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

**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

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)