



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 Unknown

Social Security Number: _____

Ethnicity: (Data is used for statistical reporting.)

Central/S Am Cuban Hispanic or Latino Not Hispanic or Latino
 Mexican Puerto Rican Patient Refused Other _____

Race: (Data is used for statistical reporting.)

American Indian Asian African American White
 Native Hawaiian/Pacific Islander Unknown Patient Refused

Religion: _____

Preferred Language: English Spanish Other _____

Need Interpreter? YES NO Comments: _____

Hearing Impaired? YES NO Comments: _____

Vision Impaired? YES NO Comments: _____

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

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 Unknown
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 Unknown
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 Atlantic Health Partners Payment Policy and Notice of Privacy Practices for more information)

Signature _____ Print Name _____ Date _____

(Guarantor/Legal Guardian Signature)

(Guarantor/Legal Guardian Print Name)