



Pleasant Run Family Physicians

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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 _____

Race: (Data is used for statistical reporting.)

American Indian Asian African American White
 Native Hawaiian/Pacific Islander Unknown Rather Not Say

Religion: _____

Patient's Contact Information

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

Home Phone: (_____) _____

Cell Phone: (_____) _____

Automated Reminder Calls/Text about Appointment YES NO

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 CARRIER: _____

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? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Has treatment been authorized by the V.A.? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Do you or your spouse have other insurance? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Are you covered under the Black Lung Program? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Are you disabled or have end stage renal disease? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Is there Medigap coverage secondary to Medicare? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Is illness/injury the result of an auto accident? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Is there insurance coverage primary to Medicare? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | | Is there employer supplemental coverage secondary to Medicare? | <input type="checkbox"/> YES <input type="checkbox"/> 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 _____