



Pleasant Run Family Physicians

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Primary Care Partners

Affiliated with
Atlantic Health System

Pediatric Family Registration Form

New Patient Edit Information

Today's Date: _____

Patient Information

Child #1: Last Name _____ First _____ MI _____
Date of Birth _____ Social Security Number: _____

Sex: M F Nonbinary Other Unknown X

Gender Identity: M F Other
 Transgender Female/Male-to-Female
 Transgender Male/Female-to-Male
 Choose not to disclose

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

Sexual Orientation: Bisexual Choose not to disclose Don't know
 Lesbian or Gay Something Else
 Straight (Not Lesbian or Gay)

Child #2: Last Name _____ First _____ MI _____
Date of Birth _____ Social Security Number: _____

Sex: M F Nonbinary Other Unknown X

Gender Identity: M F Other
 Transgender Female/Male-to-Female
 Transgender Male/Female-to-Male
 Choose not to disclose

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

Sexual Orientation: Bisexual Choose not to disclose Don't know
 Lesbian or Gay Something Else
 Straight (Not Lesbian or Gay)

Child #3: Last Name _____ First _____ MI _____
Date of Birth _____ Social Security Number: _____

Sex: M F Nonbinary Other Unknown X

Gender Identity: M F Other
 Transgender Female/Male-to-Female
 Transgender Male/Female-to-Male
 Choose not to disclose

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

Sexual Orientation: Bisexual Choose not to disclose Don't know
 Lesbian or Gay Something Else
 Straight (Not Lesbian or Gay)

Child #4: Last Name _____ First _____ MI _____
Date of Birth _____ Social Security Number: _____

Sex: M F Nonbinary Other Unknown X

Gender Identity: M F Other
 Transgender Female/Male-to-Female
 Transgender Male/Female-to-Male
 Choose not to disclose

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

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
Comments: _____

Preferred Language: English Spanish Other _____

Hearing Impaired? YES NO Comments: _____

Vision Impaired? YES NO Comments: _____

Patients' 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 NOE-Mail: _____ No Email

Home Phone: (_____) _____

Cell Phone: (_____) _____

Work Phone: (_____) _____

Alt Phone: (_____) _____

Patients' 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:** _____

Primary Pharmacy Name, Address & Phone #: _____

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:** _____

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 Primary Care Partners Payment Policy and Notice of Privacy Practices for more information)

Guarantor's Signature _____ Date _____