Atlantic Health Partners
Affiliated with
Atlantic Health System

Adult Registration Form

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☐ New Patient ☐ Edit Information

Please complete this form in order to ensure proper billing of your services. **Please Print.** Today's Date: ______________________

Patient Information- *Please provide Photo ID*

Patient Last Name: ____
First Name: ________________________________ MI __________
Alias/Preferred Name: ____

Social Security Number: ______________________________
Date of Birth: _________________________
Sex: ☐ M ☐ F ☐ Unknown

Marital Status: ☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced ☐ Life Partner
☐ Significant Other ☐ Other

Preferred Language: ☐ English ☐ Spanish ☐ Other _____________
Need Interpreter? ☐ YES ☐ NO Comments: __________________
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 ☐ Patient Refused ☐ Other ____________

Race: **(Data is used for statistical reporting.)**
☐ American Indian ☐ Asian ☐ African American ☐ White ☐
☐ Native Hawaiian/Pacific Islander ☐ Unknown ☐ Patient Refused

Religion: __________________________

Patient's Contact Information

Preferred Method of Contact: ☐ Home ☐ Cell ☐ Work
☐ Alt Phone ☐ Letter ☐ Email
Automated Reminder Calls/Text about Appointment ☐ YES ☐ NO

E-Mail: ____ ☐ No Email

Home Phone: (_______) _______________________________
Cell Phone: (______) _________________________________
Work Phone: (_______) ______________________________
Alt Phone: (________) _______________________________
☐ Patient Refused

Patient's Primary Address

Address: ____
County: ____

City, State, Zip: ______________________________________
Country: ____

Patient's Employment Information

Emp. Status: ☐ Full Time ☐ Part Time ☐ Retired
☐ Unemployed ☐ Disabled ☐ Homemaker
☐ Student ☐ Active Military ☐ Self-Employed ☐ Other _________

Employer: __________________________________
Address: ___________________________________
City, State, Zip: ____________________________
County: ________________________ Country: ___________

Patient's Emergency Contact

Emergency Contact Name.: ______________________________________
Patient's Relationship to Emerg. Cont.: ____________________________

Home Phone: (_______) ___________________________
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 CARRRIER: ______________________ Telephone #: (________) ______________________

Address: ______________________ ID/Cert #: ______________________

Group/Plan #: ____________ Effective Date: ____________ Subscriber's Name: ______________________

Subscriber's DOB: _____ SSN: ____________ Sex: ☐ M ☐ F ☐ Unknown Relationship to Patient: ______________________

SECONDARY CARRIER: ______________________ Telephone #: (________) ______________________

Address: ______________________ ID/Cert #: ______________________

Group/Plan #: ____________ Effective Date: ____________ Subscriber's Name: ______________________

Subscriber's DOB: _____ SSN: ____________ Sex: ☐ M ☐ F ☐ Unknown 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 ☐ Unknown

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 PROMPTLY PAY OTHER AMOUNTS DUE; THESE AMOUNTS MAY INCLUDE ANNUAL DEDUCTIBLES, CO-PAY OR CO-INSURANCE CHARGES*** and under some circumstances 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)

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

Guarantor/Legal Guardian Signature ______________________(Guarantor/Legal Guardian Print Name ______________________