AtlantiCare
Physician Group

Patient Registration Form

Patient Information:

Primary Care Physician:_____

Reason for NO Primary Care Physician:_____

Social Security # _____/_____/_____

Last Name: _____ First Name: _____ Middle Name: _____ Suffix_____

Preferred First Name: _____

Sex Male / Female / Transgender Birth Sex: Male/Female Date of Birth: _____/_____/_____

Preferred Language:_____

Marital Status:
Divorced /Legally Separated /Life Partner /Married /Civil Union /Registered Domestic Partner /Single /Widowed

Race: _____Ethnicities:_____

Home Address

Address Line 1 _____

Address Line 2 _____

Country_____Zip _____City _____State _____

Circle Preferred Phone Type: Alternate Phone / Home Phone / Mobile Phone / No Phone / Work Phone

Home # (___) _____-_____Cell # (___) _____-_____Work# (___) _____-_____ Work Ext_____

Alternate # (___) _____-_____

Home E-mail Address: _____

Do you wish to be enrolled into the Healthe Life Portal: Yes/No

If yes please circle a challenge question.

Challenge Question: Last four Digits of your SSN / Year you got married / Year you graduated high school / Year your father graduated high school /Year your father was born / Year your mother graduated high school / Year your mother was born / Your postal code

Challenge Answer: _____

Are you an Emancipated Minor Yes / No

Related persons:

Role: Contact /Guardian /Next of Kin /Power of Attorney

Last Name: _____ First Name: _____ Middle Name: _____ Suffix_____

Home # (___) _____-_____Cell # (___) _____-_____Work# (___) _____-_____ Work Ext_____

Alternate # (___) _____-_____Patient Relationship to Related Person: _____

Guarantor:

Self: Yes / No

Please fill out below if anything other than self:

Guarantor Legal Name:

Last Name: _____ First Name: _____ Middle Name: _____ Suffix_____

Preferred First Name: _____

Sex: Male / Female/ Transgender Birth Sex: Male/Female Date of Birth: __/_____/_____

Social Security # _____/_____/_____

Home # (___) _____-_____Cell # (___) _____-_____Work# (___) _____-_____ Work Ext_____

Alternate # (___) _____-_____

Address Line 1_____

Address Line 2_____

Country _____ Zip _____ City _____ State _____

Insurance Information:

Name of PRIMARY Insurance _____

If Medicare: Is the patient a Veteran? Y / N Are you currently employed? Y / N

Do you have a Federal Black Lung Card? Y / N Is your spouse/partner currently employed Y / N

Policy / Subscriber # _____ Group # _____

How is the Subscriber related to you? Self / Spouse / Child / Guardian

Policyholder / Subscriber Information:

First Name _____ Middle Initial _____ Last Name _____

Social Security # _____ /_____ /_____Date of Birth: ___/___/___Age: _____Sex M / F / T

Address _____

City _____State_____ Zip _____

Home Phone # (____) _____Cell Phone # (_____) _____

Subscriber's Employer _____

Work # (____) _____Employer's Address _____

City _____ State _____ Zip:_____

Name of SECONDARY Insurance Company _____

Policy / Subscriber # _____Group # _____

How is the Subscriber related to you? Self / Spouse / Child / Guardian/ Partner

Policyholder / Subscriber Information:

First Name _____ Middle Initial _____ Last Name _____

Social Security # _____ /_____ /_____Date of Birth: ____/___/___Age: _____Sex M / F / T

Address _____City _____ St _____Zip_____

Home Phone # (____) _____Cell Phone # (____) _____

Subscriber's Employer _____ Work # _____

Employer's Address _____

City _ _State __ Zip ___

Employment Status (circle one) Full-time / Part-time / Self Employed / Retired / Military

Patient's Occupation _____Work # _____

Employer _____Address_____

City _____State _____Zip_____

Is it okay to leave messages at: Work? Y / N If Student, indicate School _____
Student Status FT/ PT

Pharmacy Information:

Retail Pharmacy Name: _____

Phone # (____)_____ Fax #(____)_____Location _____

ID#_____

Mail Order Pharmacy:_____

Phone # (_____)_____ Fax # (____)_____

ID #_____