GLENS FALLS PEDIATRIC CONSULTANTS
PATIENT REGISTRATION
PATIENTS 18 YEARS AND OLDER

PATIENT NAME: _____ **DOB:** _____
First Middle Initial Last

Patient's Address:_____
Street City State Zip

Pharmacy of Choice:_____
Name Street City State Zip

Patient Email Address:_____Patient Cell Phone_____

Primary Doctor:_____

********The following questions are asked as a requirement of our Patient Centered Medical Home and NCQA recognition* and will be kept confidential if you are comfortable answering.**

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Race: ☐ **PREFER NOT TO DISCLOSE** ☐ White ☐ African American/Black ☐ American Indian or Alaska Native ☐ Asian ☐ Other: _____

Ethnic Origin: ☐ **PREFER NOT TO DISCLOSE** ☐ Not Hispanic/Latino ☐ Hispanic/Latino

Gender Identity at Birth: ☐ Female ☐ Male

Gender Identity: ☐ **PREFER NOT TO DISCLOSE**
☐ Female ☐ Male
☐ Transgender male/trans man/female-to-male (FTM) ☐ Transgender female/trans woman/male-to female (MTF) ☐ Genderqueer ☐ Other: _____

Sexual Orientation: ☐ **PREFER NOT TO DISCLOSE** ☐ Heterosexual (Straight) ☐ Homosexual (Lesbian/gay) ☐ Bisexual ☐ Don't know ☐ Other: _____

Name of Primary Insurance: _____

Subscriber's Name: _____ Subscriber's DOB: _____
Address:_____
Responsible Party (Person to Receive Billing Statements): _____

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I authorize Glens Falls Pediatric Consultants to use or disclose my personal health information (PHI) to treat my condition, obtain payment for that treatment and run the business operation. I also give my permission to disclose my personal health information (PHI) for payment activities and certain business operations of another healthcare provider or payer. In the event that my insurance carrier does not pay, I agree to be financially responsible for any debts incurred.

Signature:_____**Date:**_____

Updated 8/28/25