MOSTELLAR MEDICAL CENTER-SOUTHWEST ALABAMA HEALTH SERVICES
PATIENT REGISTRATION FORM

Patient Name: _________________________________ **Patient Account #**___________________ **Chart #**___________

PATIENT ADDRESS

Legal Patient Name:
Last: ______________________________ **First:** ______________________________________**M.I.:** ________
Title: ☐**Miss** ☐**MR.** ☐**MRS.** ☐**MS.**
Preferred Name: ____________________________ **Preferred Pronouns:** _________________________________
(He/Him, She/Her, They/Them)

Address: ____

City: ____________________ **County:** _________________________ **State:** ___________________ **Zip:** _________

PATIENT DEMOGRAPHICS

Sex: ☐Female ☐Male ☐Choose not to disclose

What is your Gender?
☐Male ☐Female ☐Trans Male (Female to Male)
☐Trans Female (Male to Female) ☐Genderqueer
☐Other ☐Choose not to disclose

Do you think of yourself as:
☐Straight or heterosexual ☐Lesbian, gay, or homosexual
☐Bisexual ☐Other ☐Unknown ☐Choose not to disclose

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Legally Separated ☐Other ☐Unknown

Home Phone: ____
Cell Phone: ____
Work Phone: ____
Best Number to Use: ☐Home ☐Cell ☐Work

Social Security Number: ______-______-______

Date of Birth: ______________________________

Email Address: ________________________________

Preferred method of contact: Please indicate how you would like us to communicate your information with you
☐Home phone, no message ☐Home phone, leave message for call back ☐Email ☐Regular Mail (Letter)
☐Cell phone, no message ☐Cell phone, leave message for call back ☐Text message
☐Work phone, no message ☐Work phone, leave message for call back ☐Patient declined

Education Level: ☐High School ☐GED
☐Less than High School ☐College Degree

Highest Grade Completed: ____________________________

FINANCIAL INFORMATION

Insurance: ____ **Secondary Insurance:** ____________________________

Employment Status: ☐Employed Full-Time ☐Employed Part-Time ☐Student Full-Time ☐Student Part-Time ☐Retired
☐Other
Please indicate if applicable: ☐Homeless ☐Migrant ☐Seasonal Worker

*****PLEASE NOTE THAT IF YOU REQUIRE ANY FINANCIAL ASSISTANCE FOR MEDICAL SERVICE, YOU MUST FILL OUT THE SLIDING FEE SCALE FORM*****

The information requested on this registration form is required by HRSA, our government funding agency. The information is confidential and utilized to provide the highest quality care for our patients.

THIS INFORMATION IS FOR DEMOGRAPHIC PUPOSES ONLY AND WILL NOT AFFECT YOUR CARE

ADDITIONAL INFORMATION

Race: ☐Asian ☐Native Hawaiian ☐Black/African American ☐Native American/Alaskan Native ☐White/Caucasian
☐More than one race ☐Other (specify)______________________ ☐Choose not to disclose

Ethnicity: ☐Hispanic/Latino/Latina ☐Not Hispanic/Latino/Latina **Country of Birth:** ☐USA ☐Other (specify)___________

Primary Language: ☐English ☐Lao ☐Spanish ☐Vietnamese ☐Other (specify)__________________ ☐Choose not to disclose

Do you need an interpreter? ☐Yes ☐No **Veteran Status:** ☐Veteran ☐Not a Veteran

Preferred Pharmacy: ____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name	Phone#	Relationship to Patient

AUTHORIZATION AND CONSENTS

I, _________________________________ give authorization for access to my personal health information either face to face, in writing or by U.S. Postal Service, Email, or Text Messaging to the following individuals:

1. ____ 2. ____

3. ____ 4. ____

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing ad arranging your medical care.

MMC or SWAHS is furnishing you with the attached notice, which provides information about how MMC or SWAHS and its physicians[1] may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have received a copy of MMC's or SWAHS' Notice of Health Information Practices.**

The EHR is a joint effort of MMC/SWAHS Network physicians and other physicians aligned with our Health System to fully support an electronic patient care experience through the implementation of a common electronic health record platform. Bayou La Batre Area Health is pleased to offer a secure EHR as a convenience to communicate electronically with you

I hereby authorize the clinical providers of Mostellar Medical Center (MMC) or Southwest Alabama Health Services (SWAHS) to provide treatment for me or my dependent(s), including such diagnostic procedures, tests, or treatments (including tests for HIV) as he/she deems necessary. I authorize Mostellar Medical Center or Southwest Alabama Health Services to furnish any insurance company information concerning the illness and treatment. I hereby assign to the clinical providers all payments for medical service rendered to me or my dependent(s). I understand that I am responsible for any amount not covered by insurance. I further understand I am responsible for any attorney's fees that may be incurred from the amount. I also acknowledge that I have been given the "Notice of Privacy Practices" flyer which describes how medical information about me, or my dependent(s) may be used and disclosed and how I can get access to this information.

Patient Name (please print) ____

✖ ____ ____

Signature of Patient, Parent, or Legal Guardian **Date**

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