MOSTELLAR MEDICAL CENTER-SOUTHWEST ALABAMA HEALTH SERVICES
PEDIATRIC PATIENT REGISTRATION FORM

Responsible Party: _____ **D.O.B.** _____ **SS #**_____
Address: _____
Phone #: _____ **Cell #:** _____ **Work #:** _____

PATIENT INFORMATION

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LEGAL NAME OF PATIENT:
Last: _____ **First:** _____**M.I.:** _____
Title: ☐**Miss** ☐**MR.** ☐**MRS.** ☐**MS.**
Preferred Name: _____ **Preferred Pronouns:** _____
(He/Him, She/Her, They/Them)
Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____
Sex: ☐Female ☐Male ☐Choose not to disclose
Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Legally Separated ☐Other ☐Unknown

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

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

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

Social Security Number: _____-_____-_____

Date of Birth: _____

Email Address: _____

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

Highest Grade Completed: _____

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

FINANCIAL INFORMATION

Insurance: _____ **Secondary Insurance:** _____
Policy Holder
Policy Holder: _____ **Date of Birth:** _____
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*****

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
Preferred Pharmacy: _____

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.

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. _____

As a legal custodian of _____, I hereby give consent to the clinical providers of Mostellar Medical Center or Southwest Alabama Health Service to provide him/her, medical treatment as deemed necessary. In the event I am not able to be present, the following individual(s) have permission to accompany patient for medical care and treatment:

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 or Southwest Alabama Health Services 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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