

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

Patient Name: _____ **Patient Account #** _____ **Chart #** _____

ADDRESS	Legal Patient Name:
	Last: _____ First: _____ M.I.: _____
	Title: <input type="checkbox"/> Miss <input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MS.
	Preferred Name: _____ Preferred Pronouns: _____ (He/Him, She/Her, They/Them)
	Address: _____
City: _____ County: _____ State: _____ Zip: _____	

DEMOGRAPHICS	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Choose not to disclose	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	What is your Gender?	Home Phone: _____
	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans Male (Female to Male)	Cell Phone: _____
	<input type="checkbox"/> Trans Female (Male to Female) <input type="checkbox"/> Genderqueer	Work Phone: _____
	<input type="checkbox"/> Other <input type="checkbox"/> Choose not to disclose	Best Number to Use: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	Do you think of yourself as:	Social Security Number: _____ - _____ - _____
	<input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Lesbian, gay, or homosexual	Date of Birth: _____
	<input type="checkbox"/> Bisexual <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Choose not to disclose	
	Email Address: _____	
	Preferred method of contact: Please indicate how you would like us to communicate your information with you	
<input type="checkbox"/> Home phone, no message <input type="checkbox"/> Home phone, leave message for call back <input type="checkbox"/> Email <input type="checkbox"/> Regular Mail (Letter)		
<input type="checkbox"/> Cell phone, no message <input type="checkbox"/> Cell phone, leave message for call back <input type="checkbox"/> Text message		
<input type="checkbox"/> Work phone, no message <input type="checkbox"/> Work phone, leave message for call back <input type="checkbox"/> Patient declined		
Education Level: <input type="checkbox"/> High School <input type="checkbox"/> GED	Highest Grade Completed: _____	
<input type="checkbox"/> Less than High School <input type="checkbox"/> College Degree		

FINANCIAL INFORMATION	Employer: _____	Occupation: _____
	Insurance: _____	Secondary Insurance: _____
	Policy Holder: _____	Patient relationship to Guarantor: _____
	Policy Holder D.O.B: _____	
	PLEASE NOTE THAT IF YOU REQUIRE ANY FINANCIAL ASSISTANCE FOR MEDICAL SERVICE, YOU MUST FILL OUT THE INCOME INFORMATION	
	Head of household: _____	Family Size: _____
	Estimated Family Income Yearly: \$ _____	
	Dependent Names: _____	

	Employment Status: <input type="checkbox"/> Employed Full-Time <input type="checkbox"/> Employed Part-Time <input type="checkbox"/> Student Full-Time <input type="checkbox"/> Student Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> Other	
Please indicate if applicable: <input type="checkbox"/> Homeless <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal Worker		

Please turn form over to complete the other side.

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) _____

Language: English Lao Spanish Vietnamese Other (specify) _____ Choose not to disclose

Primary Language: _____ **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 ASSIGNMENT

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) 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.

X Signature _____ Date: _____
 Parent/Guardian/Foster Parent/Social Worker

AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

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 following conditions are excluded from this authorization.

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

"THIS AUTHORIZATION MAY BE REVOKED, IN WRITING AT ANY TIME. THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM INITIAL SIGNATURE DATE."

X Signature: _____ Date _____

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Notice of Health Information Practices

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 and arranging your medical care.

MMC or SWAHS is furnishing you with the attached notice, which provides information about how MMC or SWAHS and its physicians¹ 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.**

Patient Name (please print)

Signature of Patient, Parent, or Legal Guardian

Date

Electronic Health Record (EHR)

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 under the conditions and terms outlined below.

Use of Electronic Communication from MMC/SWAHS to the Patient

YES, I want MMC to communicate my information with me through a secure system that is designed to keep my information safe. You will be notified via email when there is secure information for you to review. The e-mail will provide a link that will take you to the secure site. After clicking on the link, you will be required to log-in and provide a password to access your information. You will need to make note of the password to access future information.

Please enter in the space below the e-mail address you would like to use to receive secure messages.

Email Address (please print) _____

In choosing your e-mail address, please consider the privacy implications; for example, any other person that may have access to your e-mail address or any other person, such as your employer, that may have the right and/or ability to review all e-mail received at your work address.

NO, I do not want MMC or SWAHS to use electronic communication as a way to communicate my information to me.

MMC/SWAHS E-Mail Guidelines

- At this time MMC/SWAHS can only send emails to patients. Currently MMC/SWAHS is not able to accept patient emails through the secure HER system.
- All emails you receive from MMC/SWAHS is sent under the name and email account of
- The patient is responsible to notify MMC/SWAHS promptly of any changes to their email address.
- All of MMC's/SWAHS' electronic communications to you are recorded in your medical record. Those who have access to your medical record also have access to the email messages sent to you.

Confidentiality and Privacy

- If the electronic communication process described above is not used, we cannot guarantee the confidentiality of the information.
- MMC/SWAHS will not share your email address with anyone unauthorized to view your medical record.

Consent and Agreement

I have carefully reviewed this document and agree to fully comply with the guidelines defined herein for electronic communication from MMC or SWAHS. I understand that the service will be offered at no charge and that I will be notified if and when a fee is administered for the service.

Patient Name (please print) _____



Signature of Patient, Parent, or Legal Guardian

Date

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MOSTELLAR MEDICAL CENTER - SOUTHWEST ALABAMA HEALTH SERVICES

**Health Biodata Sheet
(Confidential)**

Name: _____ DOB: _____ MD: _____ Date: _____

Chart #: _____ Primary Language (please circle): English Vietnamese Laotian Spanish

Easiest way to learn: (please circle) Read Demonstrate Video/TV Pictures Individual instruction

Learning Barriers (please circle): Language Vision Hearing Psycho-social Cognitive Readiness

ALLERGIES

Please check any allergies that you have had and write down the reactions.

	Reactions
_____ Penicillin	_____
_____ Sulfa	_____
_____ Aspirin	_____
_____ Codeine	_____
_____ Bee Stings	_____
_____ Foods	_____
_____ Other	_____

MEDICATIONS

Please list any medications that you including take prescriptions and Over-the-counter medications

IMMUNIZATIONS

Please check any immunizations you or have had and write down the year it was given.

	Year
_____ Rubella	_____
_____ Measles	_____
_____ Tetanus	_____
_____ Pneumovax	_____
_____ Hepatitis-B	_____
_____ Meningococcal	_____
_____ Influenza	_____
_____ Other	_____

PAST MEDICAL HISTORY

Please check any illness you have had.

- _____ Kidney Trouble
- _____ High Blood Pressure
- _____ Asthma
- _____ Rheumatic Fever
- _____ Hay Fever
- _____ Emphysema
- _____ Diabetes

PAST MEDICAL HISTORY (cont'd)

- _____ TB
- _____ Stroke
- _____ Cancer _____
(type)
- _____ Anemia
- _____ Arthritis
- _____ Gout
- _____ Abnormal Pap Smear
- _____ Stomach Ulcer
- _____ Mental Illness
- _____ Seizures
- _____ Depression
- _____ Back Trouble
- _____ Bowel Trouble
- _____ Thyroid Disease
- _____ Glaucoma
- _____ Liver Problems
- _____ Bleeding Problems
- _____ Skin Problems
- _____ Hepatitis
- _____ Alcohol Problems
- _____ Drug Addiction
- _____ Hearing Loss
- _____ Polyps of Bowel
- _____ Sexual Transmitted Disease (VD)
- _____ Heart Trouble
- _____ Other _____

SURGICAL HISTORY

Please check any surgery you have had.

- _____ Appendix
- _____ Heart
- _____ Tonsils
- _____ Hernia
- _____ Gallbladder
- _____ Hysterectomy
- _____ Breast
- _____ D&C
- _____ Prostate

WOMEN ONLY

- Age at first menstrual period _____
- # of times pregnant _____
- # of living children _____
- Date of last Pap Smear _____
- Date of last mammogram _____
- Age when period stopped _____
- Birth control method (circle)
- Tubal Diaphragm
- Rhythm Sponge
- Vasectomy None
- Pills Condoms IUD

SOCIAL HISTORY

- | Do you: | Yes | No |
|--|-------------|-------|
| Drink Alcohol? | _____ | _____ |
| Use Drugs? | _____ | _____ |
| Use snuff or | | |
| Chewing tobacco? | _____ | _____ |
| Smoke Cigarettes? | _____ | _____ |
| (Packs per day) _____ | Years _____ | |
| Highest grade completed in school? _____ | | |

FAMILY HISTORY

Please check the diseases that your parents, grandparents, brothers or sisters have or have had.

	Family Member
_____ Diabetes	_____
_____ Asthma	_____
_____ Mental Illness	_____
_____ Stroke	_____
_____ Seizures	_____
_____ Alcoholism	_____
_____ Heart Attack	_____
_____ High Blood Pressure	_____
_____ Familial Polyposis	_____
_____ Cancer	_____
(Type of Cancer) _____	

HOSPITALIZATIONS

Please list dates and reasons for all hospitalizations.

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____

MEN AND WOMEN

- | | Yes | No |
|---|-------|-------|
| Have you had more than one sexual partner in the past year? | _____ | _____ |
| Have you had sex without using condoms? | _____ | _____ |
| Have you ever had sex with a member of the same sex? | _____ | _____ |

Patient Name		DOB		Date	
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****The below questions are formulated to assess for potential mental health and substance use needs. Please review the questions carefully and select the most appropriate answer.**

PHQ-2 (Depression Screening)

1.	In the past 2 weeks, how often have you had little interest or pleasure in doing things?			
	0 – Not at all	1 – Several Days	2 – More than half the days	3 – Nearly every day
2.	In the past 2 weeks have you felt down, depressed or hopeless?			
	0 – Not at all	1 – Several Days	2 – More than half the days	3 – Nearly every day
				Score

		None	1 or more
Men:	How many times in the past year have you had 5 or more drinks in a day? (One drink = 1 can of beer or 1 glass of wine or 1.5 oz. liquor (1 shot))		
Women:	How many times in the past year have you had 4 or more drinks in a day? (One drink = 1 can of beer or 1 glass of wine or 1.5 oz. liquor (1 shot))		
Both:	How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?		