MOSTELLAR MEDICAL CENTER-SOUTHWEST ALABAMA HEALTH SERVICES
PATIENT REGISTRATION FORM

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

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:** _____

DEMOGRAPHICS

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: _____

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

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: ☐Employed Full-Time ☐Employed Part-Time ☐Student Full-Time ☐Student Part-Time ☐Retired ☐Other
Please indicate if applicable: ☐Homeless ☐Migrant ☐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.

✖ **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."

✖ **Signature:** _____ **Date**_____

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.

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 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.**

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**

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.

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	_____
_____ Meningioccal	_____
_____ 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 menstral 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)	_____

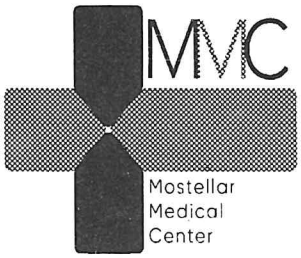
HOSPITALIZATIONS

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?	_____	_____



BAYOU LA BATRE AREA HEALTH DEVELOPMENT BOARD, INC.
MOSTELLAR MEDICAL CENTER - SOUTHWEST ALABAMA HEALTH SERVICES

SLIDING FEE SCALE PROGRAM APPLICATION

Patient:_____
First Middle Last

Home Address: _____

_____

City:_____ State: _____Zip:_____

Home/Cell Phone: _____

Date of Birth:____/____/_____

Social Security #: ____-_____-_____

Employer:_____

Employer Address:_____

_____

Employer Phone:_____

Do you have insurance? Yes_____ No_____
Insurance Name:_____
Policy #:_____

Spouse and Dependents	DOB	Insurance	Social Security No.

YEARLY INCOME_____
** Please include yearly income (if any) of the above listed spouse/dependents**

DECLARATION OF INCOME

I hereby agree to give complete and accurate information in order to determine my eligibility for reduced fees. Officials of this Health Center have permission to verify this information. I will cooperate fully by providing documentation of my income if requested. I understand that deliberate misrepresentation may result in civil and/or criminal prosecution under State and Federal Laws. Should changes in my income or family size occur during this SFS certification period, I understand that I am responsible for reporting these changes within 30 business days to this Health Center.

_____ _____
Signature of Patient or Legal Representative Date

SFS_____%

Expiration Date: _____

Application Approved by:_____Date:_____

Mostellar Medical Center
Vision Department

12701 Padgett Switch Rd Irvington, AL 36544
P.O. Box 769 Bayou La Batre, AL 36509
Phone: 251-824-2174 | Fax: 251-824-2525

Last:_____ First: _____ Sex: M F DOB:_____

Review of Medical History

Drug allergies: _____

List all medications (drug name, dosage prescribed, and over the counter): _____

_____

_____

Personal or Family History (If yes, please circle relation to patient)

Glaucoma	No	Yes	Self	Father	Mother	Sister	Brother	G'mother	G'father
Cataracts	No	Yes	Self	Father	Mother	Sister	Brother	G'mother	G'father
Macular Degeneration	No	Yes	Self	Father	Mother	Sister	Brother	G'mother	G'father
Lazy Eye	No	Yes	Self	Father	Mother	Sister	Brother	G'mother	G'father
Arthritis	No	Yes	Self	Father	Mother	Sister	Brother	G'mother	G'father
Asthma	No	Yes	Self	Father	Mother	Sister	Brother	G'mother	G'father
Heart Disease	No	Yes	Self	Father	Mother	Sister	Brother	G'mother	G'father
High Blood Pressure	No	Yes	Self	Father	Mother	Sister	Brother	G'mother	G'father
Diabetes	No	Yes	Self	Father	Mother	Sister	Brother	G'mother	G'father
Cancer	No	Yes	Self	Father	Mother	Sister	Brother	G'mother	G'father

Past surgical history: _____

_____

Previous eye problems/surgeries: _____

Do you wear contact lenses? Yes No

Do you currently wear eye glasses? Yes No

Social History (If yes, how often?)

Alcohol? Yes No _____

Tobacco? Yes No _____

Do you currently have any problems in the following areas? (If yes, explain)

Fever, fatigue, change in weight?	Yes	No	
Rash, new skin lesions?	Yes	No	
Nasal congestion,sore throat, shortness of breath, wheezing, cough?	Yes	No	
Chest pain?	Yes	No	
Nausea, vomiting, reflux?	Yes	No	
Possible pregnancy?	Yes	No	
Joint pain?	Yes	No	
Headaches?	Yes	No	
Tingling, numbness, seizures?	Yes	No	
Cold or heat intolerance?	Yes	No	
Easy bleeding or bruising?	Yes	No	
Swelling?	Yes	No	
Allergies or immune disorder?	Yes	No	
Anxiety or depression?	Yes	No	

Patient Name		DOB		Date	

****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?		