RWBAHC PATIENT REGISTRATION WORKSHEET (Continued)

IAW DHA-PI 6010.01

(Fill out completely)

Purpose: This worksheet will be used by Raymond W. Bliss Army Health Center (RWBAHC) to register new beneficiaries into the MHS Genesis Electronic Health Record.

This worksheet is to be destroyed by RWBAHC IAW HIPAA guidelines after information is entered into MHS Genesis.

Name: ______________________ DoD ID: ______________ Rank: ________

Date of Birth: ______________ Birth Sex: ____________ Race: ________________
ddmmmyyyy

Ethnicity: Hispanic or Latino (Check One) Yes No Marital Status: ____________

Preferred Language: ______________ Religious Preference: ________________

Branch of Service: (Check One) Army Marines Navy Air Force Coast Guard

Active-Duty National Guard Reserves

HOME/LOCAL ADDRESS

Address: __________________ City: ______________ State: ___ Zip Code: _____

MAILING ADDRESS

Address: __________________ City: ______________ State: ___ Zip Code: _____

CONTACT INFORMATION

Home Phone: __________ Mobile: __________ Work: __________ Preferred: _______

Appt/Referral Reminders: (Check One) Yes No

Reminder Type: (Check One) N/A Call Text Email: ____________________

Additional Messaging Consent: Yes No Leave Message on: Home Cell

PREVIOUS DUTY STATION: ____

Local Unit/UIC: ________________________________ (**ATTACH COPY OF ORDERS)**

(Students) – Graduation Date: ____________________ MOS-T IET

Flying Status: (Check One) Yes No

MHS GENESIS PATIENT REGISTRATION WORKSHEET

IAW DHA-PI 6010.01

(Fill out completely)

EMERGENCY CONTACT

Name: ______________________ Specify Relationship Status: ____________

Address: ______________________ City: ________________ State: ______

Zip Code: ______________________ Phone: ______________________

NEXT OF KIN INFORMATION

Name: ______________________ Specify Relationship Status: ____________

Address: ______________________ City: ________________ State: ______

Zip Code: ______________________ Phone: ______________________

FAMILY MEMBERS (Permanent Party)

(IF ACCOMPANING YOU)

Name: __________________ Date of Birth: ______________ Race: __________
ddmmmyyyy

Ethnic Origin: ______________ Birth Sex: ____________ Relationship: __________

Name: __________________ Date of Birth: ______________ Race: __________
ddmmmyyyy

Ethnic Origin: ______________ Birth Sex: ____________ Relationship: __________

Name: __________________ Date of Birth: ______________ Race: __________
ddmmmyyyy

Ethnic Origin: ______________ Birth Sex: ____________ Relationship: __________

Name: __________________ Date of Birth: ______________ Race: __________
ddmmmyyyy

Ethnic Origin: ______________ Birth Sex: ____________ Relationship: __________

MTF name where Family Members(s)' medical records are located:

____

This document may contain information covered under the Privacy Act, 5 USC 552 a, and/or the Health Insurance Portability and Accountability Act (HIPAA) PL 104-191 and its various implementing regulations and must be protected in accordance with those provisions. Healthcare information is personal and sensitive and must be treated accordingly.