

Patient Registration Form

Reason for Visit

Mark all that apply: Immunizations Compliance Form 121 Family Planning WIC Other _____

Patient Demographic Information

Patient's Name: Last: _____ First: _____ Middle Initial: _____
 Patient's SS#: _____ Sex: Female Male Date of Birth: ____/____/____
 Street Address: _____ Apt/Lot #: _____
 City: _____ State: _____ Zip: _____
 Mailing Address: _____ May we contact you? Yes No

(If Different from Above)

Home Phone: (____) _____ Work Phone: (____) _____ Mobile Phone #: (____) _____
 Email Address: _____ Interpreter Needed: Yes No
 Language: English Spanish Vietnamese Other _____ Homeless: Yes No
 Marital Status: Married Single Widow Divorced
 Ethnicity: Hispanic/Latino Non-Hispanic/Latino
 Race: American Indian or Alaskan Native Asian Black or African American White
 Native Hawaiian or Other Pacific Islander Multiracial Other _____
 Accident related: Yes No

Emergency Contact Information

Name: _____ Relationship: _____
 Address: _____ Phone #: (____) _____

Employment, Guarantor, and Insurance Information

Employer: _____ Address: _____
 Employment Status: Employed Not Employed Full-time Part-time
 Type of Guarantor Account: Personal/Family Additional Type Personal/Family
 Who is responsible for this guarantor account?
 Self Employer Spouse Father Mother Other _____
 Guarantor's Name: _____ SS#: _____ Sex: Female Male
 Date of Birth: ____/____/____ Phone #: (____) _____

If you are a minor completing this form, please check all that applies:

- Child Protection Services (Foster Care or Protection Service Center) Emancipated Minor with legal documentation
 Reproductive Services (Family Planning or STD/HIV Services) Minor Parent

Does the patient have, or is the patient covered by health insurance? Yes No If yes, complete Insurance Coverage.

Primary Insurance Coverage	Secondary Insurance Coverage
Member relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian <input type="checkbox"/> Other	Member relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian <input type="checkbox"/> Other
Member/Insurance ID#:	Member/Insurance ID#:
Member Effective From Date:	Member Effective From Date:
Member Effective To Date:	Member Effective To Date:
Subscriber ID/SS #: _____ DOB: _____	Subscriber ID/SS #: _____ DOB: _____
Subscriber Address:	Subscriber Address:
Group Number:	Group Number:
Auth Phone:	Auth Phone:
Group Name:	Group Name:
Covered Through:	Covered Through:
Name on Card:	Name on Card:

Family Size: _____ Proof of Income: Yes No
 Type of Income: Hourly Wages: _____ No of hours/week: _____ Monthly Salary: _____
 Interest/dividends Pension Social Security Income 1 Social Security Income 2
 Government Assistance Supp Sec Income Alimony/child support Other non-wage Income

I have been offered voter registration and I accepted _____ / declined _____

By my signature below, I certify that the above information is correct to the best of my knowledge.

Signature: _____ Date: _____
 Self Parent Guardian Other (Specify) _____

Mississippi State Department of Health Form Instructions

PATIENT REGISTRATION

FORM NUMBER F-143

REVISION DATE 01/14/2021

RETENTION PERIOD The form will be scanned into EPIC as part of the patient medical record, which will have the same retention period as other EPIC medical records. The hard copy will be destroyed after being scanned into EPIC.

PURPOSE

To collect patient demographic and financial information, emergency contact, guarantor (person responsible for bill) and insurance information necessary for patient registration and billing.

INSTRUCTIONS

This form is to be completed on all patients:

- as they sign in;
- with home visits; or
- when downloaded from MSDH website and the patient presents to the health department a completed Form 143.

All information must be entered into EPIC to register new patients or update existing patient records and as applicable to determine eligibility for specific programs. Income information is not required for patients receiving Immunizations and/or TB Skin Test. Information should be entered before that day's point of service exit to reflect the correct sliding fee scale pay category

OFFICE MECHANICS AND FILING

The information collected on this form should be updated annually, every April 1st and whenever there is a change in patient's information. The completed and signed form will be scanned into EPIC.