PATIENT REGISTRATION FORM

(Please fill out this form completely)

Registration Clerk: _____ Date: _____

Patient Information:

Name (Last, First Middle): _____

Sponsor's SSN: _____N/A__ Your SSN:_____ Sex: ☐

Religious Preference:_____ DOB:_____

Ethnicity (check one)☐ Filipino ☐ Hispanic ☐ Southeast Asian ☐ Asian/Pacific Islander ☐ Other:_____

Race (check one): ☐ Asian ☐ Black ☐ Western Hemisphere Indian ☐ White ☐ Other: _____

Marital Status (check one):☐ Annulled ☐ Divorced ☐ Interlocutory ☐ Legally Separated ☐ Married ☐ Single ☐ Widowed

Home Address: _____

State: Zip Code: Home Phone: ( ) Work Phone: ( )

Emergency Contact Information:

Name (Last, First MI):_____ Relationship: _____

Address: _____

State:_____ Zip Code:_____ Home Telephone: (_____)_____

Next-of-Kin Information:

Name (Last, First MI):_____ Relationship: _____

Address: _____

State:_____ Zip Code:_____ Home Telephone: (_____)_____

Sponsor Information:

Name (Last, First MI):_____N/A_____ Flying Status: ☐

Service: _____N/A_____ Rank: _____N/A_____ MOS/Rate/Designator_____N/A_____

Command: _____N/A_____ Length of Service: _____N/A_____

Duty Address: _____N/A_____

State:_____ Zip Code:_____ **Duty Telephone:** (_____)_____

Other Health Insurance: *(Please do not include TRICARE)*

Are you covered by private health insurance: ☐ If Yes, please complete DD FORM 2569.

I certify that the information on this form is complete and correct to the best of my knowledge.

_____ _____

Patient Signature Date

Email completed form to:

dha.bethesda.wrnmmc.mbx.patient-accountability@health.mil

WHEN SENDING TO THIS EMAIL ADDRESS YOU WILL HAVE TO ENCRYPT DUE TO "PII "or it WILL NOT go through to this email.- YOU CANNOT SEND THIS FROM AN OUTSIDE PERSONAL EMAIL ADDRESSS.

ELECTRONIC HEALTH RECORD APPLICATION USER REGISTRATION ***PRIVACY ACT 1974***

1. TYPE OF REQUEST: Select One: **DATE:**

2. USER INFORMATION

FIRST NAME | **MIDDLE INITIAL** | **LAST NAME**

DOD ID + 6-DIGIT PIV | + PIV | **GOV E-MAIL (@health.mil)**

RANK / PAY GRADE | **JOB TITLE/POSITION** | **OFFICE PHONE NUMBER**

DATE CYBER AWARENESS TRAINING COMPLETED | **DATE HIPAA TRAINING COMPLETED**

MTF PARENT COMMAND	
PRIMARY MTF LOCATION/DMIS ID (Key West/0517; Miramar/0232, etc.)	
ADDITIONAL MTFs/SITES SUPPORTED (if applicable)	
PRIMARY CLINIC (Emergency; Dental; PAD; etc.) Additional clinics supported? See Section 8	
PRIMARY MEDICAL ROLE Dental Roles in Section 5	*Select One:
SECONDARY MEDICAL ROLE	Select One (if applicable):
TERTIARY MEDICAL ROLE	Select One (if applicable):
CREDENTIAL	None
SECONDARY CREDENTIAL (if applicable)	Select (if applicable)
3. ARE YOU A CREDENTIALED HEALTH CARE PROVIDER?	YES ○ NO ◉
NATIONAL PROVIDER IDENTIFIER NUMBER (NPI)	
TAXONOMY	
PRIMARY SPECIALTY	Select Primary Specialty
4. WILL YOU BE PRESCRIBING CONTROLLED SUBSTANCES?	YES ○ NO ◉
DEA NUMBER	
Required for SPI registration* **BUSINESS FAX NUMBER	
Required for SPI registration* **BUSINESS PH NUMBER	
5. ARE YOU DENTAL PERSONNEL?	YES ○ NO ◉
Will you need to take workload and/or will appointments be scheduled with you? *(i.e. Dentist, Registered Hygienist, Prophy Tech)*	YES ○ NO ◉
(*Dentists, Dental Residents, Hygienists, EFDA/OPAs*) **provide NPI:**	
Primary dental clinic where you will need login/work:	
List any additional dental clinics supported	
PRIMARY DENTAL ROLE	Select One:
ADDITIONAL DENTAL ROLE	
6a. ARE YOU NATIONAL GUARD OR RESERVE?	YES ○ NO ◉
If so, enter active order end date:	
6b. ARE YOU A STUDENT, RESIDENT, INTERN OR FELLOW?	YES ○ NO ◉
If yes, when do you graduate?	
Training Status	Select (if applicable)

PROVIDERS ONLY: All providers require review and concurrence from local Medical Staff Management (Credentialing office) indicating provider is appropriately credentialed & privileged IAW DHA-PM 6025.13.

Medical Staff Management CAC Signature:

7a. INCLUDE BOLT ONS/APPS? Clairvia [Select One] Clairvia Location [ ]
Ex. USA-BAMC COTO MED/SURG ICU 3T

Blood Bridge [Select One:] ☐ MHS Video Connect ☐ iAccess

☐ HealtheRegistries(HeR) ☐ HealtheAnalytics (HeA) HeR/HeA DMIS(s): [ ]
(Individually list all DMIS IDs supported, to include child DMIS IDs)

☐ Immunizations Inventory Management- *(Enter location(s) & select appropriate view)* DMIS(s) [ ]

View [Select Imms Inventory View]

7b. ADDITIONAL PERMISSIONS

Will your job duties include the management of preference cards? YES ○ NO ◉

Will your job duties include the scheduling of patient appointments? YES ○ NO ◉

Will your job duties include the ordering/requisitioning of supplies? YES ○ NO ◉

If yes, what DMIS: [ ] & Clinic Location(s): [ ]

8. AREAS SUPPORTED? (Check all that apply)

☐ Ambulatory Clinics	☐ L&D
☐ Ancillary Services	☐ Med/Surg
☐ Behavioral Health	☐ Mother Baby
☐ Billing	☐ Neonatal
☐ Case Management	☐ OB/Maternity
☐ Coding	☐ Occ Health
☐ Dental Care	☐ Oncology
☐ Emergency Dept	☐ OpMed/OPFOR
☐ Flight Medicine	☐ PACU/Recovery
☐ ICU	☐ Patient Admin
☐ Inpatient Ward	☐ Readiness/SRP
☐ Immunizations	☐ UBO
☐ Other: [ ]	

9. COMMENTS: (*Add'l notes, modification details, TDY return dates, Final Out date, etc.)*

[ ]

ELECTRONIC HEALTH RECORD - USER REGISTRATION

PRIVACY ACT OF 1974

Authority: 10 U.S.C, Section 3013.
Purpose: To authenticate that the individual is an authorized user or health care provider in the Electronic Health Record Application.
Routine users: Information may be disclosed outside of DoD agencies as outlined in AR 340-21, para 3-2 (Blanket Routine User)
Disclosure: Mandatory. Failure to provide required information may delay your access to the Electronic Health Record application.

PRIVACY ACT OF 1974
*** APPLICANT MUST READ AND SIGN ***

The purpose of this document is to verify that I have read and understood my responsibilities for safeguarding my access and the integrity of the Electronic Health Record (EHR).
The Privacy Act of 1974 imposes responsibilities to prevent misuse or compromise data concerning individuals. It has three main provisions:

1.**CONFIDENTIALITY OF INFORMATION**. Most of the information within the EHR is sensitive, personal medical information. Only authorized people or agents are allowed to disclose this information.
2.**DATA INTEGRITY**. Patient treatment decisions are made from the EHR information. Users of the system are responsible for ensuring that all data entered into the EHR is accurate.
3.**DATA SECURITY**. The Privacy Act requires safeguards for confidential and secure records. This entails protective measures for preventing accidental or malicious alteration, destruction, or disclosure of PII/PHI that could affect medical care or the patient's privacy.

I am responsible for all of the following security related guidelines as laid down in DOD and DA directives. My access is unique to me. It MUST BE KEPT CONFIDENTIAL. Any action I make on the system may be audited by the EHR Database Administrator (DBA).
I must memorize my PIN and will not make a written record of my PIN. If I suspect that someone else is using my password, I must change my password immediately and notify the EHR DBA.
I understand that I am specifically prohibited from using any other person's password. I understand that I am also prohibited from attempting to enter the system by guessing or randomly entering passwords.
I understand that my access to the EHR program does NOT, in and of itself, give me authority to disclose patient data to anyone.
I have read and understood the security guidelines given above and the necessity for safeguarding my password and the integrity of the EHR. I understand that if I divulge my password or information that is protected by the Privacy Act, I may be prosecuted under the Uniform Code of Military Justice or the United States Code (5 U. S. C., 552a (1)).

IMPORTANT --- NON-PROVIDER USERS --- IMPORTANT

As a user of the EHR application in a non-health care provider status, I am aware that the access level that I will be given may display a menu option for ordering medications. I have been advised of the command policy, which prohibits me from accessing this menu option. I also understand that I am not authorized under any circumstances to place medication orders in the EHR application.
I further acknowledge that violation of this policy will result in disciplinary action as set forth by the Commanding Officer, including immediate loss of access to the EHR application, possible dismissal and/or punishment under the Uniform Code of Military Justice

I certify that I have read and understand the Privacy Act statement above and furthermore, I declare that, to the best of my knowledge, the information provided in this application is true and accurate.

Applicant CAC Signature	

I certify that, as the applicant's supervisor or designee, I have reviewed this application and confirm that the level of access requested is both necessary and appropriately aligns with the applicant's scope of work.

Supervisor CAC Signature	
Supervisor's DoD Email Address	
Supervisor's Office Phone	