PRESIDIO OF MONTEREY ARMY HEALTH CLINIC

REGISTRATION FORM

_____ _____ _____

SPONSORS NAME (LAST, FIRST, MIDDLE INITIAL) SPONSORS SSN RANK

_____ MALE / FEMALE MARRIED / SINGLE

SPONSORS BIRTH DATE

RELIGIOUS PREFERENCE: _____

ETHNICITY: Filipino Hispanic SE Asian Asian/Pacific Islander Other_____

RACE: Asian- Pacific Islander Black Western Hemisphere Indian White Other_____

BRANCH OF SERVICE: ARMY NAVY MARINES AIR FORCE COAST GUARD FM

SPONSORS UNIT:

ARMY: HHC A. Co 229 B. Co 229

TELEPHONE # _____ C. Co 229 D. Co 229 E. Co 229 F. Co 229

LOCAL ADDRESS: _____ AIR FORCE: 314 TRS 311 TRS 517 TRS

_____ NAVY: CIDU Student CIDU Staff

_____ MARINE: MCD Student MCD Staff

KNOWN DRUG ALLERGIES: _____

ARE YOU AN ORGAN DONOR? YES / NO

EMERGENCY CONTACT

NAME_____ RELATIONSHIP_____

ADDRESS_____ STATE_____ ZIP CODE_____

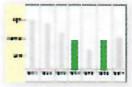
PHONE # _____

*****THE ABOVE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.*****

SERVICE MEMBERS SIGNATURE AND DATE: _____

SECURE MESSAGING SIGN-UP

E-mail a Doctor or Nurse



Get Your Lab Results

Request Appointments

Request Medication Refills

Please fill out the information below to initiate Secure Messaging with your provider team:

Last Name, First Name:

DOB (mm/dd/yyyy):

Circle Gender: M or F

DOD ID#

Personal Email address or the one linked to your phone:

Primary Care Provider (if unknown leave blank):

TEMP PROVIDER

We are collecting your email address to issue you an invitation to enroll in our online secure communication service. Enrollment is optional. We will not disclose your address to others without your prior written consent.

Please return to front desk!

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER *(SSN)*

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

3. ROUTINE USES

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/ beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF PATIENT OR SPONSOR	SSN OF MEMBER OR SPONSOR	DATE

REQUEST FOR MEDICAL/DENTAL RECORDS OR INFORMATION

REQUESTING ACTIVITY - Complete Items 1 through 10 *(Except 8b)*; also complete Item 19.

ADDRESSEE - Complete Items 8b, 11 to 14 or 15 to 18, as appropriate. final referrer shall return to requester.

DATE

1. PATIENT *(Last Name - First Name - Middle Name)*

2. ORGANIZATION AND PLACE OF TREATMENT

3. STATUS ☐ MILITARY ☐ VA BENEFICIARY ☐ DEPENDENT ☐ FEDERAL EMPLOYEE ☐ OTHER *(Specify)*

3a. NAME OF SPONSOR *(If dependent)*

4. TO *(Include ZIP Code)*

5. IDENTIFYING INFORMATION

a. SERVICE NUMBER

b. GRADE/RATE

c. SOCIAL SECURITY ACCOUNT NO.

d. VA CLAIM NUMBER

e. DATE OF BIRTH *(If Federal employee)*

6. DATES OF TREATMENT *(Inclusive)*

7. DISEASE OR INJURY

8. a. RECORDS REQUESTED

MIL	VA		b. RECORDS FORWARDED MIL	VA
☒	☐	CLINICAL	☐	☐
☒	☐	OUTPATIENT	☐	☐
☒		HEALTH RECORD	☐	
☐	☐	DENTAL RECORD	☐	☐
☒	☐	X-RAY	☐	☐
☒		MEDICAL REPORT CARDS, EMERGENCY MEDICAL TAGS, FIELD MEDICAL CARDS	☐	
	☐	ABSTRACT OF RATING SHEET		☐
☒	☐	REPORT OF PHYSICAL EXAMINATION	☐	☐
☒		ALL AVAILABLE RECORDS *(Except X-rays unless specifically requested)*	☐	
☐	☐	OTHERS *(List under remarks)*	☐	☐

9. REMARKS

10. SIGNATURE

REPLY/REFERRAL

11. TO:

12. REMARKS

☐ RECORDS CHECKED IN 8b FORWARDED.
☐ NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.
☐ MORE INFORMATION NEEDED. FURNISH FOLLOWING:

13. SIGNATURE

14. DATE

REPLY/SECOND REFERRAL

15. TO:

16. REMARKS

☐ RECORDS CHECKED IN 8b FORWARDED.
☐ NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.
☐ MORE INFORMATION NEEDED. FURNISH FOLLOWING:

17. SIGNATURE

18. DATE

19. RETURN TO: *(Include ZIP Code)*

REQUESTING ACTIVITY WILL ENTER COMPLETE ADDRESS TO WHICH RECORDS OR FINAL REPLY SHOULD BE MAILED.

DD FORM 877, SEP 67

REPLACES EDITION OF 1 JAN. 60, WHICH MAY BE USED.