MaineHealth

SHARED ELECTRONIC HEALTH RECORD REGISTRATION

For Downtime Use Only

See MaineHealth Shared EHR Downtime Policy and Appendix A for Procedures

A. Patient Information

Is this visit Pregnancy Related? ❑ Yes ❑ No	Expected Due Date	OB/GYN Provider
Legal First Name	Legal Last Name	Legal MI
Please list below all names or aliases used by the patient in any healthcare facility	Preferred Name	
Date of Birth	Social Security Number	
Legal Sex: ❑ Male ❑ Female ❑ X ❑ Unknown	Gender Identity: ❑ Female ❑ Male ❑ Transgender Female ❑ Transgender Male ❑ Non-Binary ❑ Other _____ ❑ Choose Not to Disclose	

Mailing Address:	City	State	Zip
Physical Address (if different):	City	State	Zip
Home Phone	Cell Phone		Work Phone
Language Interpreter Needed? ❑ Yes ❑ No	Preferred language to discuss healthcare information	Written Language	
Sign Language Interpreter Needed? ❑ Yes ❑ No	Is Patient Hard of Hearing? ❑ Yes ❑ No	Is Patient Deaf? ❑ Yes ❑ No	Does patient need an Assisted Listening Device at the time of services? ❑ Yes ❑ No

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Significant Other ❑ Legally Separated ❑ Domestic Partner ❑ Declined ❑ Unknown	Race ❑ White or Caucasian ❑ Black/African American ❑ Asian ❑ Native Hawaiian/Other Pacific Islander ❑ Multi-Racial ❑ Alaska Native/American Indian ❑ Other ❑ Declined ❑ Unknown	Ethnicity ❑ Hispanic ❑ Declined ❑ Non-Hispanic ❑ Unknown	Ethnic Background
Does patient have an advanced directive or will? ❑ Yes - Received ❑ Yes – Not Received ❑ No ❑ Inactive ❑ Unknown	Religious Preference	Place of Worship	Primary Care Physician

B. EMERGENCY CONTACT

Last Name	First Name		Relationship
Legal Guardian ❑ Yes ❑ No	Share Health Information with Contact ❑ Yes, Share ❑ No, Do NOT Share	Notify this contact if admitted to Hospital ❑ Yes, Notify ❑ No, Do NOT Notify	
Street Address	City	State	Zip
Home Phone	Cell Phone	Work Phone	

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C. Guardian/Patient Information *if patient is a minor (under 18 years of age) please provide information for both parents or guardians*

Guardian/Parent #1

Last Name	First Name	Relationship	
Date of Birth	Social Security Number	Sex ☐ Male ☐ Female ☐ X ☐ Unknown	
Street Address (if different than patient)	City	State	Zip
Home Phone	Cell Phone	Work Phone	
Employment Status ☐ FT ☐ PT ☐ Self-Employed ☐ Active Military Duty ☐ Retired ☐ Not Employed ☐ Student-FT ☐ Student-PT ☐ Unknown	Employer or Retired From	Employer's Phone Number	
Employer's Address	City	State	Zip

Guardian/ Parent #2

Last Name	First Name	Relationship	
Date of Birth	Social Security Number	Sex ☐ Male ☐ Female ☐ X ☐ Unknown	
Street Address (if different than patient)	City	State	Zip
Home Phone	Cell Phone	Work Phone	
Employment Status ☐ FT ☐ PT ☐ Self-Employed ☐ Active Military Duty ☐ Retired ☐ Not Employed ☐ Student-FT ☐ Student-PT ☐ Unknown	Employer or Retired From	Employer's Phone Number	
Employer's Address	City	State	Zip

D. Visit Related Information

Accident Related (if yes, complete the following fields in this section) ☐ Yes ☐ No	Accident Type ☐ Automobile ☐ No-Fault Insurance ☐ Other/No Liability ☐ Recreational Vehicle ☐ Third Party Liability ☐ Tort Liability ☐ TPL-Patient Declined ☐ Worker's Compensation	Date of Injury	Place of Injury
		Auto Accident State	Body Part Injured
Injury Description			
Workers Comp Employer		Workers Comp Insurance	
Workers Comp Claim No.		Authorization Number	

Hospital/Inpatient Visits ONLY

Does the patient request the encounter be private ☐ Yes ☐ No	If yes, do they have a code word?
Does the patient request their PCP be notified of this visit ☐ Yes ☐ No	

State of ME, Emergency or Urgent Care Departments Only

Has patient served in the United States Armed Forces (active duty, reserve duty or National Guard?) ☐ Yes ☐ No ☐ Declined

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. Other Health Insurance (Including Workers Comp or Other Liability): *If different from Patient*

rimary Insurance

oes insurance card include one of these logos: ❑ First Health ❑ Cigna ❑ Aetna ❑ Mednet ❑ Multiplan

Claims Address	City	State	Zip	Phone Number
Patient Relation to Subscriber	Insurance ID	Effective Date	Subscriber ID	
Group Number	Group Name	Auth Phone Number		

Subscriber (Policy Holder) Demographics

Last Name	First Name	Relationship	
Date of Birth	Sex ❑ M ❑ F ❑ X ❑ Unknown	Social Security Number	
Street Address	City	State	Zip
Home Phone	Cell Phone	Work Phone	
Employment Status ❑ FT ❑ PT ❑ Self-Employed ❑ Active Military Duty ❑ Retired ❑ Not Employed ❑ Student-FT ❑ Student-PT ❑ Unknown	Employer or Retired From	Employer's Phone	
Employer Address	City	State	Zip

Secondary Insurance

Does insurance card include one of these logos: ❑ First Health ❑ Cigna ❑ Aetna ❑ Mednet ❑ Multiplan

Claims Address	City	State	Zip	Phone Number
Patient Relation to Subscriber	Insurance ID	Effective Date	Subscriber ID	
Group Number	Group Name	Auth Phone Number		

Subscriber (Policy Holder) Demographics *(if different than Patient's)*

Last Name	First Name	Relationship	
Date of Birth	Sex ❑ M ❑ F ❑ X ❑ Unknown	Social Security Number	
Street Address	City	State	Zip
Home Phone	Cell Phone	Work Phone	
Employment Status ❑ FT ❑ PT ❑ Self-Employed ❑ Active Military Duty ❑ Retired ❑ Not Employed ❑ Student-FT ❑ Student-PT ❑ Unknown	Employer or Retired From	Employer's Phone	
Employer's Address	City	State	Zip

Signature of Person Completing Form: _____ Date Completed: _____

All information is subject to verification