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 Auto Accident State	Place of Injury 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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E. Insurance Information *Please complete section applicable to patient's insurance coverage*

→ Please notify the insurance company of the patient's visit as soon as possible ←

Indicate the insurance coverage the patient has and complete the applicable section number. If the patient has multiple coverages, please fill out all related coverage sections. Please read insurance card from front and back. Contact the insurance company for any referrals, notification or prior authorization requirements.

❑ 1. Medicare/Medicare Replacement/Medicare HMO ❑ 2. Medicaid ❑ 3. Tricare ❑ 4. Commercial/Other Insurance

❑ Patient does not have coverage / Self-Pay ❑ Does the patient want further information on Financial Assistance?

1. Medicare/Medicare Replacement/Medicare HMO *(Complete this section if patient has Medicare/Medicare Replacement/Medicare HMO)*

MBI#	Part A Effective Date	Part B Effective Date	
Does patient have a Medicare Replacement/Medicare HMO product? ❑ Yes ❑ No	Product Name	Telephone Number	
Claims Address	City	State	Zip
Policy Number	Group Number		

Below is required by the Centers for Medicare and Medicaid Services

Are services covered by Federal Black Lung Program? ❑ Yes ❑ No	Are services covered by Research Grant? ❑ Yes ❑ No
Is patient entitled to benefits through the Department of Veterans Affairs? ❑ Yes ❑ No	Is patient entitled to Medicare based on (select all that apply)? ❑ Age ❑ Disability ❑ End Stage Renal Disease
Do working age or disability MSP provisions apply? (Ex: is the GHP already primary based on age or disability entitlement?) ❑ Yes ❑ No	
Patient Retirement Date (if applicable)	Spouse Retirement Date (if applicable)

Is patient undergoing dialysis? ❑ Yes ❑ No	If yes, please list last date of dialysis	Has patient had a kidney transplant? ❑ Yes ❑ No	If yes, please list the date of the kidney transplant
Is patient within 30 month coordination period? ❑ Yes ❑ No	If yes, please list date coordination began	Did patient participate in self-dialysis training program? ❑ Yes ❑ No	If Yes, date training program started:

Does patient have Group Health Insurance based on their own or spouse's current employment: ❑ Yes ❑ No	If yes, does the employer that sponsors the Group Health Insurance Employ: ❑20+ employees ❑ 100+ employees ❑N/A

2. Medicaid/Medicaid Replacement *(Complete this section if patient has Medicaid/Medicaid Replacement Plan)*

Medicaid Number	State Providing Medicaid	Is patient's Medicaid called Managed Maine Care? ❑ Yes ❑ No	Effective Date

3. Tricare *(Complete this section if patient has a Tricare Plan)*

Which Tricare Plan: ❑ Tricare Standard ❑ Tricare Prime ❑ Tricare for Life	Policy Number
Sponsor's Name	Sponsor's SSN

Sponsor's Date of Birth	Branch of Service	Status: ❑ Active ❑ Retired ❑ Deceased

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

Primary 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

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