

# REGISTRATION

NAVAL MEDICAL CENTER SAN DIEGO

AUTHORITY FOR INPATIENT ADMISSION (ESTIMATED LENGTH OF STAY: MORE THAN 24 HRS)

AMBULATORY PATIENT VISIT (APV) (ESTIMATED LENGTH OF STAY: LESS THAN 24 HRS)

Please Print

PART I: (TO BE COMPLETED BY ADMITTING PHYSICIAN)				
Admit to Ward <input checked="" type="checkbox"/>	ROOM NO	(Check One) <input type="checkbox"/> ERA <input type="checkbox"/> ROUTINE <input type="checkbox"/> URGENT	ADMISSION DATE <input checked="" type="checkbox"/>	REGISTER NUMBER
TYPED BY		REVIEWED BY		ADMISSION TIME:
PROFESSIONAL SERVICES		STAFF PHYSICIAN (NAME) (Please Print)		STAFF PHYSICIAN SIGNATURE

INPATIENT MEPRS CODES (CIRCLE ONE)					
AABA	CARDIOLOGY	ACBA	OBSTETRICS	ABIA	PLASTIC SURGERY
ABBA	CARDIOVASCULAR/THORACIC SURGERY	ABFA	ORAL SURGERY	AFAA	PSYCHIATRY (IN/IW)
ABAA	GEN SURGERY	AEAA	ORTHOPEDECS	ABKA	UROLOGY
ACAA	GYNECOLOGY	ABGA	OTOLARYNGOLOGY		
AAAA	INTERNAL MEDICINE	ADAA	PEDIATRICS		
ABDA	NEUROSURGERY	ABHA	PEDIATRICS SURGERY		
ADBA	NURSERY	ABNA	PERIPHERAL VASCULAR SURGERY		

DIAGNOSIS ONE	<input checked="" type="checkbox"/>	ICD9
SCHEDULE PROCEDURE # 1	<input checked="" type="checkbox"/>	PROCEDURE CODE #1
SCHEDULE PROCEDURE # 2		PROCEDURE CODE #2

PART II PATIENT INFORMATION									
LAST NAME: <input checked="" type="checkbox"/>			FIRST NAME: <input checked="" type="checkbox"/>			MIDDLE NAME: <input checked="" type="checkbox"/>		SEX:	
HOME ADDRESS: <input checked="" type="checkbox"/>					APT/CONDOMINIUM NO: <input checked="" type="checkbox"/>		SSN: <input checked="" type="checkbox"/>		
CITY: <input checked="" type="checkbox"/>			STATE: <input checked="" type="checkbox"/>		ZIP CODE: <input checked="" type="checkbox"/>		HOME PHONE: <input checked="" type="checkbox"/>		
WORK PHONE: <input checked="" type="checkbox"/>		RACE: <input checked="" type="checkbox"/>		ETHNIC BACKGROUND: <input checked="" type="checkbox"/>		RELIGION: <input checked="" type="checkbox"/>		DOB: (DD-MM-YY) <input checked="" type="checkbox"/>	AGE: <input checked="" type="checkbox"/>
<input checked="" type="checkbox"/> MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED						IF FAMILY MEMBER IS A CHILD, IDENTIFICATION ON DEERS: _____ <input checked="" type="checkbox"/>			
<input checked="" type="checkbox"/> CATEGORY: <input type="checkbox"/> ACDU <input type="checkbox"/> FAMILY MBR (ACDU) <input type="checkbox"/> FAMILY MBR (ACDU DECEASED) <input type="checkbox"/> RET <input type="checkbox"/> FAMILY MBR (RET) <input type="checkbox"/> FAMILY MBR (RET DECEASED) <input type="checkbox"/> OTHER _____									
IF BEING ADMITTED FOR CHILD DELIVERY, WHAT NUMBER CHILD WILL THIS BE (CIRCLE ONE) 1 <sup>ST</sup> , 2 <sup>ND</sup> , 3 <sup>RD</sup> , 4 <sup>TH</sup> , 5 <sup>TH</sup> OTHER _____ EDC: _____ Normal C-Section									

DEERS INFORMATION CHECKED BY PAD Representative				
ID CARD NUMBER (Minor without ID CARD, use sponsor's number)	EXPIRATION DATE	ELIGIBILITY	DOB	Sex
Name Of PAD Representative (Please Print)		Signature of PAD Representative		Date

PART III: SPONSOR INFORMATION (IF YOU ARE ACDU OR RETIRED - YOU ARE YOUR OWN SPONSOR)					
SPONSOR'S LAST NAME <input checked="" type="checkbox"/>		FIRST NAME: <input checked="" type="checkbox"/>		MIDDLE: <input checked="" type="checkbox"/>	
SSN: <input checked="" type="checkbox"/>	RATE/RANK: <input checked="" type="checkbox"/>	DESIG/MOS/AFSC <input checked="" type="checkbox"/>	TIME IN SERVICE: <input checked="" type="checkbox"/>	FLY STATUS:	BRANCH OF SERVICE: <input checked="" type="checkbox"/>
LOCAL UIC:	COMPLETE MILITARY ADDRESS (SHIP-STATION-UNIT-DIVISION-FPO/FP-NAVY RECRUITS CO./NO MARINE RECRUITS CO./NO/BN/PLT)				
	CITY:		STATE:		ZIP:
DUTY STATION PHONE NUMBER ( )		IS ACDU MILITARY SPONSOR: STAFF                  STUDENT                  INSTRUCTOR			
PART IV: EMERGENCY DATA OF PRIMARY NEXT OF KIN FOR PATIENT					
NAME: (Last, First, Middle)			RELATION:		
ADDRESS (Street)    Same as Patient			HOME PHONE:		
CITY			STATE	( )	
			ZIP CODE		
PART V: ACCIDENT/INJURY INFORMATION					
IF INJURED WERE YOU					
DUTY		OFF DUTY		OTHER THAN ACTIVE DUTY MEMBER	
EXPLAIN:			TIME AND DATE OF ACCIDENT		
IF MOTOR VEHICLE ACCIDENT, WERE YOU DRIVER                  PASSENGER			WHERE YOU TRANSFER FROM ANOTHER HOSPITAL    YES    NO		
ORIGINAL ADMISSION DATE:			NAME OF TRANSFERRING HOSPITAL:		

TITLE 18 USC, SECTION 1001. Statements or entries generally:

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry shall be fined not more than \$10,000 or imprisoned not more than five years, or both.

I HAVE READ AND UNDERSTAND; SECTION 1001 TITLE 18 USC, QUOTED ABOVE AND I CERTIFY UNDER PENALTY OF LAW THAT ALL INFORMATION ON THIS FORM IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: <input checked="" type="checkbox"/>	DATE: <input checked="" type="checkbox"/>
--	---

PATIENT:

DATE OF BIRTH:

SPONSOR'S SSN:

**GENERAL CONSENT TO TREATMENT**

1. I consent to undergo all necessary routine tests, medication, treatment and other procedures required in the course of the study, diagnosis and treatment of my illness by the staff and other agents and/or employees of the Naval Medical Center San Diego including medical students. I understand that this is a teaching medical center and that training doctors is one of the activities of the medical center.

2. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of my treatment or examinations in the medical center.

3. I consent to the release of medical information to other institutions or agencies accepting me as a patient for medical treatment, and to the release of medical information to my insurer that is necessary for treatment, payment or healthcare operations.

4. I hereby authorize the release of my Social Security Number to a manufacturer of medical equipment in the event I receive a medical device in accordance with federal law and regulations. I further understand that if there is a need to contact me with regard to this device my Social Security Number may be used by the manufacturer to help locate me.

5. I understand that access to medical records for bona fide research and quality assurance is permitted to members of the medical and medical center staff. I authorize my medical records and results to be used for research. I realize that my records will not be identified as pertaining to me specifically without my expressed permission.

6. I further understand that:

- a. No patient will be involved in any research or experimental procedure without his or her full knowledge and consent; and
- b. Each patient has the right to consent, or to refuse consent, to any proposed procedure or therapeutic course; and
- c. The possibility exists that during my hospitalization, healthcare workers may be directly exposed to my blood or body fluids. In the event of such a direct exposure in a manner which may, according to the Centers for Disease Control guidelines, transmit AIDS (Acquired Immune Deficiency Syndrome), and other blood borne diseases, a sample of my blood will be tested for the presence of infectious disease such as hepatitis, syphilis, and AIDS. I further understand that the results of the tests will be released to me and to any healthcare worker who suffered an exposure.

7. I agree to abide by the rules of the medical center, including to the extent I am able, cooperation with the physician in my care and treatment, and observance of the rights of other patients.

8. Title 10 of U. S. C. Sections 1075 and 1078 require the Secretary of Defense to collect charges for inpatient general medical care provided in a Military Treatment Facility (MTF). This charge will be collected from all active duty, retired officers and family members for each day of hospitalization. Enlisted retirees and TRICARE Prime family members of active duty are exempt from charges. The following is a schedule of the daily charges for the current fiscal year: **Active Duty: no charge. Retired Service Member: no charge. Family Members of Active Duty enrolled in Prime: no charge. Family Members of Active Duty not enrolled in Prime, and Family Members of Retirees: \$15.05 17.05**

9. There will be a charge for all meals provided to patients receiving outpatient services. A patient who requests food service, or who is offered and accepts food service delivery, and who has not been "admitted" to the MTF, shall be considered a patron of the dining facility and charged for each meal received at the current rate. The Office of Management and Budget, Washington, D.C establishes meal rates annually. Meal rates for current fiscal year are: **Breakfast: \$2.10 Lunch: \$3.85 Dinner: \$3.85**

This form has been fully explained to me, and I am satisfied that I understand its content and significance.

\_\_\_\_\_  
 Patient or Legal Guardian Signature (required if under age 18)      Date

\_\_\_\_\_  
 Witness signature

## ADVANCE DIRECTIVE AND PATIENT RIGHTS ACKNOWLEDGEMENT

You have the right to make decisions regarding your medical care. You also have the right to appoint someone to make medical decisions for you if you are unable to make those decisions yourself.

An "advance directive" is a written instruction, such as a living will or durable power of attorney for health care, relating to the provisions of health care when the individual is incapacitated.

It is Naval Medical Center policy to inform patients of the availability of living wills and durable powers of attorney for health care which direct the staff not to perform excessive measures in terminal or otherwise appropriate cases. Please ask your nurse or physician about an advance directive if interested. Provision of care is not conditioned on whether an individual has executed an advance directive.

PLEASE READ THE FOLLOWING STATEMENTS, CIRCLE THE APPROPRIATE CHOICES, AND SIGN BELOW

- 1. I have been given written materials about patient rights and responsibilities.
- 2. I have been informed of my rights to formulate Advance Directives at any time.
- 3. I understand that I am not required to have an Advance Directive in order to receive treatment at this health care facility.
- 4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law. To facilitate compliance with my Advance Directive, I realize that this facility needs a copy within 24 hours of my admission. If unable to obtain a copy, I understand that I may execute (orally or in writing) another Advance Directive.
- 5. I HAVE / HAVE NOT executed an Advance Directive.
- 6. I DO / DO NOT wish to execute an Advance Directive at this time.

PATIENT'S SIGNATURE:  \_\_\_\_\_ DATE:  \_\_\_\_\_

SIGNATURE OF WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_

COMPLETED BY ADMISSIONS STAFF WHEN PATIENT IS UNAVAILABLE AT TIME OF ADMISSION  
The patient was unable to complete this form at the time of admission due to the following reasons:

ATTENTION TO PATIENTS! Please bring a copy of your Advance Directives to be filed in your Outpatient Medical Record and anytime you are admitted to the Hospital. If we do not have a copy of your Advance Directive, we may not be able to honor your wishes regarding life-sustaining procedures. If you have additional questions, please contact NMCSD Legal Department (619) 532-6475.

### RELEASE OF INFORMATION DISCLOSURE

You have the right to request that information about your admission to this hospital not be released to outside persons. If you choose this restriction, individuals contacting the hospital inquiring about your presence or status in the hospital will not be given this information. However, this information will be released when necessary for treatment, payment or healthcare operations. You may choose to revoke this restriction at any time verbally or in writing, and it applies only to this admission. If you have any questions, you may call admissions at (619) 532-8366.

~~ADVERSE PERSONNEL: THIS RESTRICTION DOES NOT APPLY TO INFORMATION REQUESTED BY YOUR COMMAND OR REQUIRED IN ORDER TO CARRY OUT THE MILITARY MISSION.~~

- I have been informed of my rights to have information about my admission restricted, and I DO / I DO NOT request this restriction.

\_\_\_\_\_  \_\_\_\_\_  
PATIENT or LEGAL GUARDIAN SIGNATURE DATE

\_\_\_\_\_  
WITNESS NAME / SIGNATURE

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

X

SSN OF MEMBER OR SPONSOR

X

DATE

X