



DEPARTMENT OF THE NAVY
NAVAL HEALTH CLINIC
ANNAPOLIS, MARYLAND 21402-5050

I-DAY 2023
MRG – MINI REGISTRATION FORM

PATIENT NAME: LAST, FIRST MIDDLE INITIAL		
FULL SSN:	DOB:	DOD:
SEX: M <input type="checkbox"/> F <input type="checkbox"/>	PATCAT: N14	MARITAL STATUS: SINGLE
ETHNIC ORIGIN: FILIPINO /HISPANIC /OTHER /ASIAN (PACIFIC ISLAND) /SE ASIAN /UNKNOWN		
RACE: ASIAN /BLACK /OTHER /UNKNOWN /WEST HEMIS INDIAN /WHITE		
RELIGIOUS PREFERENCE:		
PATIENT ADDRESS:		
• NAME		
• ADDRESS 1:		
• ADDRESS 2		
• CITY, STATE, ZIP		
• PHONE: H: _____ C: _____		
LOCAL UIC: N0161		ORGAN DONAR: Y <input type="checkbox"/> N <input type="checkbox"/>
ALLERGIES: Y <input type="checkbox"/> N <input type="checkbox"/>		IF YES, LIST ALLERGY: _____ _____

SELF

SIGNATURE

RELATIONSHIP

DATE