Children's Hospital Boston

* M R 0 0 9 6 *

Use Plate, Label, or Print:

Name:

CH MRN#:

DOB: Gender: M F

MASTER PATIENT INDEX DEMOGRAPHICS CHANGE FORM

Complete and sign this form to request a Name Change or Correction to Name, Date of Birth or Sex. You must submit legal documentation (see page 2) with this form for a change to be made to a patient's name. The patient (if over 18) or parent/legal guardian must sign this form before the name can be changed in the Master Patient Index.

Only the Medical Records Services Department is authorized to make this change.

Medical Records Department
Children's Hospital Boston
300 Longwood Avenue
Boston MA 02115

You may submit this form by Fax to: 617-730-0327

If you need help completing this form, please contact the Medical Records Department at 617-355-7544.

Patient Information on File

Confirm the spelling of the patient's name (first/last and middle initial), his/her date of birth and address.					
Old Patient Last Name		**Old First Name**		**Old MI**	
Old Home Street Address				**Old Apt#**	
Old City		**Old State**		**Old Zip**	
Old SS#		**Old Home Telephone**	( )		
Old Date of Birth		**Old Alternate Telephone**	( )		

Corrected Patient Information

Confirm the spelling of the patient's name (first/last and middle initial), his/her date of birth and address.					
New Patient Last Name		**New First Name**		**New MI**	
New Home Street Address				**New Apt#**	
New City		**New State**		**New Zip**	
New SS#		**New Home Telephone**	( )		
New Date of Birth		**New Alternate Telephone**	( )		

Reason for Change/Correction

❒ **Marriage** ❒ **Divorce** ❒ **Adoption** ❒ **Misspelling**

❒ **Other* (Please Specify)**

❒ **Date of Birth Error** ❒ **Sex Error**

Requester Information

Signature (required for name change)

Signature of Patient (if over 18 years of age)	**Name of Patient (please print)**	**Date**
Signature of Parent or Guardian	**Name of Parent or Guardian (please print)**	**Date**

Relationship to the patient:

File This Form in the Patient's Medical Record after the Duplicate MRN Has Been Merged

Acceptable Forms of Legal Documentation to Support a Name Change Request

- Original or certified copy of a **birth certificate** issued by a state, county, municipal authority, or outlying possession of the US bearing an official seal
- **Adoption papers** issued by a state, county, municipal authority, or outlying possession of the US bearing an official seal
- US **social security card** issued by the Social Security Administration
- **Certification of Birth Abroad** issued by the Department of State (Form FS–545 or Form DS–1350)
- **ID card issued by a federal, state, or local government** agency or entity (eg, MassHealth ID card)
- **Military dependent's ID card**
- **US Passport** (unexpired or expired)
- **Driver's license or ID card** issued by a state or outlying possession of the US, provided it contains a photograph or information, such as name, date of birth, sex, height, eye color, and address
- **Voter's registration card**
- **Court-issued papers establishing a name change** from a state, county, municipal authority, or outlying possession of the US bearing an official seal
- **Marriage license** issued by a state, county, municipal authority, or outlying possession of the US bearing an official seal
- **Divorce decree** issued by a state, county, municipal authority, or outlying possession of the US bearing an official seal
- **Native American tribal document**
- **US Military card or draft record**
- **US Coast Guard Merchant Mariner Card**
- **US Citizen ID Card** (INS Form I–197)
- **Certificate of US Citizenship** (INS Form N–560 or N–561)
- **Certificate of Naturalization** (INS Form N–550 or N–570)
- **Alien Registration Receipt Card** with photograph (INS Form I–151 or I–551)
- **Unexpired Temporary Resident Card** (INS Form I–688)
- **Driver's license** issued by a **Canadian** government authority
- **Valid foreign passport,** with I–551 stamp or attached INS I–94 indicating current employment authorization

Medical Records Department — Internal Use

Date of Change _____

Initials _____ **ID#** _____

- Fax this form to the Blood Bank when a change/correction is made during an inpatient admission.
- File this form in the patient's medical record once the change/correction is made.

Notes _____