School – Based Health Center Registration Form

*Please help us serve you better and comply with our reporting requirements by providing the following **confidential** information.*

Student's Name: _____ ☐ Female ☐ Male
Last First Middle

Student's School ID: _____ Birth Date: _____ Social Security # _____
(Required)

Student's Address: _____ City _____ Zip Code _____

Phone: _____

Contact Name: _____ Phone: _____ Relationship to Student: _____

Is the Student Spanish/Hispanic/Latino? ☐ Yes ☐ No

Which of the following best describes the student's race? (Check One)

☐ African American/African Native ☐ American Indian/Alaskan Native ☐ Asian
☐ Pacific Islander ☐ White ☐ Multi-Racial

Supplemental Information

Who referred the student to the clinic?: _____ Student's Grade?: _____

Does the student have permanent place to live? ☐ Yes ☐ No

What is the student's preferred language: _____ Family Language: _____

Is the student eligible for the Free or Reduced Lunch Program? ☐ Yes ☐ No ☐ Don't Know

List activities in which the student is involved: _____

Medical / Mental Health History

Does the student have any medical problems or mental health concerns? _____

Does the student need medication on a regular basis? _____ What? _____

Has the student ever had any surgery, serious illness, or injury? _____

Does the student have allergies to any medications? _____

Has anyone in the student's family had the following (Check all that apply)

☐ Asthma ☐ Diabetes ☐ Heart Problems/Stroke ☐ Mental Health Problems ☐ Alcohol or Chemical use
☐ Cancer ☐ Seizures ☐ High Blood Pressure ☐ High Cholesterol ☐ Died Before Age 50

Insurance Information

You can support the Health Center by providing your insurance or Medicaid information. *Completion of the information below is <u>required</u>* ***so that we can bill your insurance company, if applicable. No one will be denied services due to inability to provide this information.***

Is the student insured? ☐ Yes ☐ No Insurance ☐ Don't Know

Plan Type: ☐ Medicaid/Healthy Options ☐ Basic Health Plan ☐ Private/Commercial

Insurance / Plan Name: _____ Group/Policy Number: _____

Subscriber's Name: _____ Subscriber's SSN: _____

Subscriber's Birth Date: _____ Sex M / F Relationship to patient: Parent/ Guardian, Patient: _____

Does the student have a doctor? ☐ Yes ☐ No If yes, please provide name and phone number _____

Consent to Release Information to Insurance Carrier: I certify the information supplied above is accurate. I authorize release of medical and related information to my health insurance company or other third party payer for the purpose of obtaining payment for services rendered. Policies are in place to assure privacy is maintained related to confidential services.

Signature: _____ Date: _____ Relationship to Student: _____