

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 #: _____
(optional)

Student's Address: _____ Student Cell: _____
Street City State Zip

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 a doctor? Yes No

If yes, please provide name and phone number _____

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 medications 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 required 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 Group Health

Insurance Company: _____ Plan Name: _____

Policy Holder's Name: _____ Policy Holder's Social Security #: _____
(optional)

Group Number or Medicaid 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 payor 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: _____