STAYWELL HEALTH CENTER STUDENT REGISTRATION FORM 2017

1. Social Security	Student's Legal Name* 2. First 3. Middle Initial 4. Last	5. Preferred name:

6. Birth Sex (please check one)* ☐ Female ☐ Male ☐ Choose not to answer

State ID# or License #

**While StayWell recognizes a number of genders/sexes, many insurance companies & legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing & correspondence. If your preferred name and pronouns are different from these, please let us know.*

A. This information is for demographic purposes only and will not affect your care. The Bureau of Primary Care of the United States government requires StayWell Health Center Request this information.

7. What is your gender Identity?

☐ Female
☐ Male
☐ Transgender Male/Female-to-Male
☐ Transgender Female/Male-to-Female
☐ Genderqueer; Neither exclusively Male or Female
☐ Other
☐ Choose not to Answer

8. Do you think of yourself as:

☐ Straight
☐ Gay
☐ Lesbian
☐ Bisexual
☐ Something Else
☐ Don't Know
☐ Choose not to answer

9. Date of Birth
Month / Day / Year

10. Marital Status

☐ Married
☐ Partnered
☐ Single
☐ Divorced
☐ Other _____

11. Race (Check all that apply):

☐ Black / African American
☐ White
☐ American Indian / Alaskan Native
☐ Asian
☐ Native Hawaiian
☐ Native American
☐ Pacific Islander
☐ Unreported / Refused to Report
☐ More than one Race
☐ Other _____

12. (Ethnicity) Do you think of yourself as:

☐ Hispanic or Latino
☐ Not Hispanic/Latino
☐ Other
☐ Not Reported/Refused

13. Preferred Language: *(Choose one)*

☐ English
☐ Spanish
☐ Albanian
☐ Portuguese
☐ Other _____

Country of Birth

☐ USA Other_____
☐ Choose not to answer

14. Employment Status

☐ Employed
☐ Self- Employed
☐ Unemployed
☐ Disabled
☐ Retired
☐ Student full time
Grade Level_____
☐ Student part time
Other _____

B. This information is for demographic purposes only and will not affect your care. The Bureau of Primary Care of the United States government requires StayWell Health Center request this information.

15. Local Address	City	State	16. Zip
Billing Address (If different from above)	City	State	Zip
17. Parent/Guardian Email Address:			

18. Home Phone	19. Mobile Phone:	20. Work Phone:	21. Preferred number to use: ☐Home ☐Cell ☐Work
Ok to leave voicemail? ☐Yes ☐ No	**Ok to leave voicemail?** ☐Yes ☐ No	**Ok to leave voicemail?** ☐Yes ☐ No	**22. Preferred Method of communication:** ☐Voice ☐Text ☐ E-mail

Emergency Contact Name: **Phone Number** **Relationship to patient**

If you are under 19, the department of Public Health requires that you provide parent/guardian contact information.
Parent/Guardian Name: **Phone Number** **Relationship to patient**

»

StayWell Health Center will send certain correspondence, such as bills, to your mailing address. How would you prefer to receive other types of written correspondence? *(Check one)* ☐ Secure E-mail ☐Letter ☐Other(Pick-up)

Patient Occupation Employer/School Name Are you covered under school or employer's insurance ☐Yes ☐ No

Pharmacy Name:	Pharmacy Phone Number:
Veteran Status: Veteran ☐ Not a Veteran	**Do you have special needs do to impairment?** ☐ Hearing ☐Vision ☐ Wheelchair ☐ Other: _____

23. What is your Primary insurance?

☐ Private -

ID#: _____Group#: _____

Contract#: _____

☐ Medicaid - **ID#_____**

☐ Medicare - **ID#_____**

☐None / Uninsured (***Self-Pay***)

24. What is your Secondary insurance?

☐ Private -

ID#: _____ Group#: _____

Contract#: _____

☐ Medicaid - **ID#_____**

☐ Medicare - **ID#_____**

25. For Federal UDS Reporting Purpose ONLY please provide:

Family Size _____ Estimated Family Income $ _____

Refuse to Report: ☐

26. Person responsible for bill (Complete if different from patient)

Guarantor Name: _____

Social Security Number:

Relationship to Patient: (**please check**) ☐ Spouse ☐ Parent or Guardian

Date of Birth:

Address: _____

_____

Phone Number:

Employer Name:

Employer Address: _____

_____

Employer Phone Number:

27. What is your housing situation today?

- ☐ I live in my home which I rent, lease or own. (***Not Homeless***)
- ☐ I am staying with friends and/or extended family members on a temporary basis (***Doubling-up***)
- ☐ I live in a public or private facility that provides temporary shelter (shelter, mission, motel, single room occupancy) (***Transitional***)
- ☐ I have been released form an institution (jail or Hospital) without stable housing to return to. (***Homeless***)
- ☐ I live on the streets, in a car, park, sidewalk, abandoned building, or other unstable non-permanent situation. (***Street)***
- ☐ I live in a foster care environment. (***Other)***

Are you worried about losing your housing?

☐ Yes ☐No ☐ I choose not to answer

28. Public Housing : ☐ Yes ☐No

Consent for Treatment, Payment & Data Agreement

Patient Name: _____ Date: _____ Time: _____

I hereby grant permission for the StayWell attending physician and/or other professional Medical/Dental staff to treat me and any family members for routine Medical/Dental/Behavioral Health care. For emergency situations when I cannot be reached, I give permission for my minor dependents to be treated for the emergency condition.

As part of your procedure or tests, patients may be tested for Human Immunodeficiency Virus (HIV) and such testing is voluntary and you may choose not to be tested.

Assignment of Benefits: I hereby authorize the staff of StayWell to render such services as may be deemed necessary to me, or my child. I hereby authorize release of all necessary information to insurance companies or other payers, & assign to StayWell Health Center the right to claim & collect insurance benefits. I request the payment of authorized benefits be made on my behalf. I assign the benefits payable for hospital/clinic (or physicians) services to the hospital hospital/clinic (or physicians) furnishings the services, and authorize SHC to submit claims to potential third-party payors for me.

Self-Pay: I understand that if my health plan does not consider SHC or any other provider under contract with them, a participating provider, charges incurred will be paid by me. I further agree to accept full financial responsibility for payment of charges. In addition, if claims for damages arise as a result of the injuries for which I am being treated, I authorize my attorney/agent to pay all unpaid medical-dental-behavioral health bills owed to SHC related to the injuries out of any proceeds that I receive from any third party.

I certify that the above information is true and correct. I have received a copy of StayWell Health Center's Notice of Privacy Practices (HIPAA) and Patient Rights & responsibilities.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____Date: _____

Office Use Only

Reviewed By: _____

Date: _____

STAYWELL HEALTH CENTER STUDENT REGISTRATION FORM 2017

SCHOOL BASED HEALTH CENTER REGISTRATION FORM

(Please Circle Which School Your Child Attends)

Driggs Elementary School - Crosby High School - Wallace Middle School – Wilby High School – North End Middle School

STUDENT'S NAME:	GRADE:	TEACHER NAME/MIDDLE SCHOOL HOUSE:

Student's email: _____ **Student's Cell phone # (if applicable): (___)_____**

Do you have any other children at this school? ☐ Yes ☐ No **Names & Grades:**_____

Who is your child's pediatrician & in what city? _____ **Pediatricians Phone # (___)_____**

Where does your child go for dental care? _____

CHILD'S HEALTH HISTORY

1. ☐ Yes ☐ No Does your child have any allergies to medications, foods, bees, or other substances?
   i. If yes, what are they allergic to? _____
   ii. If yes, what kind of reaction do they have? ☐rash ☐ trouble breathing ☐other _____
   iii. If yes, does your child require an Epi–Pen at school? ☐ Yes ☐ No
2. ☐ Yes ☐ No Does your child have any chronic medical conditions such as Asthma, Diabetes, Sickle Cell Anemia, ADHD, Seizures
   i. If yes, what are they? _____
3. ☐ Yes ☐ No Does your child have any heart problems for which he/she needs to be medicated before having dental work?
   i. If yes, what are they? _____
4. ☐ Yes ☐ No Does your child regularly take medications?
   i. If yes, what are they? _____
   ii. Dosage _____ How often_____
5. ☐ Yes ☐ No Has your child ever been hospitalized or had surgery?
   i. Why? _____
6. Is your child experiencing any of the following behaviors/symptoms? Check all that apply

   ☐ Anxiety
   ☐ Depressed mood
   ☐ Anger
   ☐ Difficulty with concentration
   ☐ School problems (behavioral, academic, social)
   ☐ Difficulty with peers
   ☐ Self-injurious behaviors
   ☐ Impulsivity

   ☐ Other (please specify): _____
7. ☐ Yes ☐ No Do you want your child to receive counseling services?

It is important to return a new enrollment form each year. If there are changes in my child's insurance, health, medications, living situation, phone numbers, I understand that it will be my responsibility to inform the School-Based Health Center of these changes. If a new form is not received, the clinician will use the latest available health information on file to make treatment decisions. This permission is valid as long as your child attends this school. I give permission to share my child's information with the school's nurse, appropriate school personnel and to release information to my child's PCP for coordination of care.

I give permission for my child to be treated and to receive the following services:

- ☐ Medical Services and/or Vaccines, if sick at school and sick follow-up; physicals upon request preferably with parent present
- ☐ Dental Services: screenings, cleanings, sealants, fluoride treatment and dental x-rays throughout the school calendar year.

  Date of last dental exam: _____
- ☐ Behavioral Health/Counseling Services as needed
- ☐ I refuse all of the above service.

_____ Signature

_____ Printed Name

_____ Date