StayWell Health Center
Growing a healthier community one person at a time.

Patient Registration Form

1. Social Security #	Legal Name* 2. First	3. Middle Initial	4. Last	5. Preferred name

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

**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.*

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 to request this information.

7. What is your gender Identity?

☐ Female
☐ Male
☐ Transgender Male/Female-to-Male
☐ Transgender Female/Male-to-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

☐ Single
☐ Married
☐ Divorced
☐ Widowed
☐ Other _____

11. Race (Check all that apply):

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

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

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

13. Preferred Language: *(Choose one)*

☐ English
☐ Spanish
☐ Albanian
☐ Portuguese
☐ Other _____

14. Employment / Student Status

☐ Employed
Employer:_____
☐ Self- Employed
☐ Unemployed
☐ Retired
☐ Disabled
☐ Other _____

☐ Student full time
☐ Student part time
Grade Level_____

15. Local Address: Street	City	State	16. Zip

Billing Address (If different from above) City State Zip

17. Email Address: We will send you an invitation to join our Patient Health Portal for access to your health record.

Please ask the front desk for more details.

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

23. Person Responsible for Bill (Complete if different from patient)

Guarantor Name: _____ Date of Birth: _____ Social Security Number: _____

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

Address: _____

StayWell Health Center
Growing a healthier community one person at a time.

Patient Registration Form

24. Household Income and Size. This information is for grant & UDS reporting purposes only. No personally identifiable information is ever reported. **This section helps us to receive funding to provide your care**.

How many people live in your household? _____

What is the total income for your household: $ _____ Weekly / Monthly / Yearly ☐ I Decline to Report

25. What is your housing situation today? (Choose one)

- ☐ 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)*** **Public Housing**: ☐ Yes ☐ No

26. Are you a refugee? ☐ Yes; **Country of birth: _____** ☐ No ☐ Choose not to answer

27. Are you a veteran? ☐ Yes ☐ No

28. Are you a migrant or seasonal worker? ☐ Yes ☐ No

If yes, are you: ☐ Migrant ☐ Seasonal ☐ Choose not to answer

29. What is your Primary insurance?	**30. What is your Secondary insurance?**
☐ Medicaid/ HUSKY - **ID#**_____	☐ Medicaid/ HUSKY - **ID#**_____
☐ Medicare - **ID#**_____	☐ Medicare - **ID#**_____
☐ Private Insurance name-_____	☐ Private Insurance name-_____
ID#: _____**Group#:** _____	**ID#:** _____**Group#:** _____
☐ **Medical** ☐ **Dental** ☐ **Behavioral Health**	☐ **Medical** ☐ **Dental** ☐ **Behavioral Health**

Additional insurance coverage: Insurance name _____**ID#:** _____
☐ **Medical** ☐ **Dental** ☐ **Behavioral Health**

☐ None / I am Uninsured (***Self-Pay***) Please ask about our Sliding Fee Discount Program.

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

If you are under 19, the department of Public Health required 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)

Pharmacy Name & Location:		**Pharmacy Phone Number:**	
Do you require any special accommodations?			

StayWell Health Center
Growing a healthier community one person at a time.

Patient Registration Form

Patient Name: _____

Consent for Treatment: 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 SWHC to submit claims to potential third-party payors for me.

Self-Pay: I understand that if my health plan does not consider SWHC 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 SWHC related to the injuries out of any proceeds that I receive from any third party.

☐ **I have been given the opportunity to apply for the StayWell Sliding Fee Discount Program and I DO NOT wish to apply for the StayWell Sliding Fee Discount Program at this time. I understand I can still apply in the future.**

Notice of Privacy Practices: StayWell's Notice of Privacy Practices describes how protected health information about you may be used and disclosed. Protected health information is any information about you that relates to your past, present, or future physical or mental health, as well as related health care services. This Notice also describes your rights to access and control your protected health information, and how you can get access to this information. Please review it carefully. **By law, we are required to provide you with our NOTICE OF PRIVACY PRACTICES.**

Acknowledgement of Notice of Privacy Practices: I hereby acknowledge that I have received a copy of StayWell's **NOTICE OF PRIVACY PRACTICES** and **PATIENTS RIGHTS & RESPONSIBILITIES.** I understand that if I have questions or complaints regarding my privacy rights that I may contact StayWell's Privacy Officer. I further understand that the practice will offer me updates to this **NOTICE OF PRIVACY PRACTICES** should it be amended, modified, or changed in anyway.

I certify that the above information is true and correct.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____Date: _____

Office Use Only

Reviewed By: _____

Date: _____

STAYWELL HEALTH CENTER STUDENT REGISTRATION FORM

SCHOOL BASED HEALTH CENTER HEALTH HISTORY

(Please Circle The 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? _____

Does your child have behavioral health services? ☐ Yes ☐ No

If yes, please provide: Provider Name: _____Phone # (____) _____

STUDENT'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 Have you brought the medication and authorization to the school nurse? ☐ Yes ☐ No
2. ❑Yes ❑No Does your child have any chronic medical conditions such as Asthma, Diabetes, Sickle Cell Anemia, ADHD, Seizures?
   i. 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. Yes, what are they? _____
4. ❑Yes ❑No Does your child regularly take medications?
   i. Yes, what are they? _____
   ii. dosage _____ how often_____
5. ❑Yes ❑No Has your child ever been hospitalized or had surgery?
   i. Why? _____
6. ❑Yes ❑No 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): _____

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 Primary Care Provider for coordination of care.

I give consent for my child to receive preventive services;

❑Medical, ❑Dental, including x-rays and ❑Behavioral Health. (*Please check all that apply)*

_____ Signature

_____ Printed Name

_____ Date