

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)* <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Choose not to answer <small>*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.</small>					State ID# or License #

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? <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Male/Female-to-Male <input type="checkbox"/> Transgender Female/Male-to-Female <input type="checkbox"/> Genderqueer; Neither exclusively Male or Female <input type="checkbox"/> Other <input type="checkbox"/> Choose not to Answer	8. Do you think of yourself as: <input type="checkbox"/> Straight <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Something Else <input type="checkbox"/> Don't Know <input type="checkbox"/> Choose not to answer	9. Date of Birth Month / Day / Year 10. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____	11. Race (Check all that apply): <input type="checkbox"/> Black / African American <input type="checkbox"/> White <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Unreported / Refused to Report <input type="checkbox"/> More than one Race <input type="checkbox"/> Other _____
12. (Ethnicity) Do you think of yourself as: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Other <input type="checkbox"/> Not Reported/Refused	13. Preferred Language: (Choose one) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Albanian <input type="checkbox"/> Portuguese <input type="checkbox"/> Other _____ Country of Birth <input type="checkbox"/> USA <input type="checkbox"/> Other _____ <input type="checkbox"/> Choose not to answer	14. Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Student full time Grade Level _____ <input type="checkbox"/> Student part time <input type="checkbox"/> 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:
Ok to leave voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	Ok to leave voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	Ok to leave voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
			22. Preferred Method of communication:
			<input type="checkbox"/> Voice <input type="checkbox"/> Text <input type="checkbox"/> E-mail
Emergency Contact Name:		Phone Number	Relationship to patient
<i>If you are under 19, the department of Public Health requires that you provide parent/guardian contact information.</i>			
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) <input type="checkbox"/> Secure E-mail <input type="checkbox"/> Letter <input type="checkbox"/> Other(Pick-up)			
Patient Occupation	Employer/School Name	Are you covered under school or employer's insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	

Pharmacy Name:	Pharmacy Phone Number:
Veteran Status: Veteran <input type="checkbox"/> Not a Veteran	Do you have special needs do to impairment? <input type="checkbox"/> Hearing <input type="checkbox"/> Vision <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other: _____

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<p>23. What is your Primary insurance? <input type="checkbox"/> Private - ID#: _____ Group#: _____ Contract#: _____ <input type="checkbox"/> Medicaid - ID# _____ <input type="checkbox"/> Medicare - ID# _____ <input type="checkbox"/> None / Uninsured (<i>Self-Pay</i>)</p>	<p>24. What is your Secondary insurance? <input type="checkbox"/> Private - ID#: _____ Group#: _____ Contract#: _____ <input type="checkbox"/> Medicaid - ID# _____ <input type="checkbox"/> Medicare - ID# _____</p> <p>25. For Federal UDS Reporting Purpose ONLY please provide: Family Size _____ Estimated Family Income \$ _____ Refuse to Report: <input type="checkbox"/></p>
<p>26. Person responsible for bill (Complete if different from patient) Guarantor Name: _____ Social Security Number: _____ Relationship to Patient: (please check) <input type="checkbox"/> Spouse <input type="checkbox"/> Parent or Guardian Date of Birth: _____ Address: _____ _____ Phone Number: _____ Employer Name: _____ Employer Address: _____ _____ Employer Phone Number: _____</p>	<p>27. What is your housing situation today? <input type="checkbox"/> I live in my home which I rent, lease or own. (<i>Not Homeless</i>) <input type="checkbox"/> I am staying with friends and/or extended family members on a temporary basis (<i>Doubling-up</i>) <input type="checkbox"/> I live in a public or private facility that provides temporary shelter (shelter, mission, motel, single room occupancy) (<i>Transitional</i>) <input type="checkbox"/> I have been released from an institution (jail or Hospital) without stable housing to return to. (<i>Homeless</i>) <input type="checkbox"/> I live on the streets, in a car, park, sidewalk, abandoned building, or other unstable non-permanent situation. (<i>Street</i>) <input type="checkbox"/> I live in a foster care environment. (<i>Other</i>)</p> <p>Are you worried about losing your housing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I choose not to answer</p> <p>28. Public Housing : <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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) furnishing 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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								
<p>1. <input type="checkbox"/> Yes <input type="checkbox"/> No Does your child have any allergies to medications, foods, bees, or other substances?</p> <p style="margin-left: 40px;">i. If yes, what are they allergic to? _____</p> <p style="margin-left: 40px;">ii. If yes, what kind of reaction do they have? <input type="checkbox"/> rash <input type="checkbox"/> trouble breathing <input type="checkbox"/> other _____</p> <p style="margin-left: 40px;">iii. If yes, does your child require an Epi-Pen at school? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. <input type="checkbox"/> Yes <input type="checkbox"/> No Does your child have any chronic medical conditions such as Asthma, Diabetes, Sickle Cell Anemia, ADHD, Seizures</p> <p style="margin-left: 40px;">i. If yes, what are they? _____</p> <p>3. <input type="checkbox"/> Yes <input type="checkbox"/> No Does your child have any heart problems for which he/she needs to be medicated before having dental work?</p> <p style="margin-left: 40px;">i. If yes, what are they? _____</p> <p>4. <input type="checkbox"/> Yes <input type="checkbox"/> No Does your child regularly take medications?</p> <p style="margin-left: 40px;">i. If yes, what are they? _____</p> <p style="margin-left: 40px;">ii. Dosage _____ How often _____</p> <p>5. <input type="checkbox"/> Yes <input type="checkbox"/> No Has your child ever been hospitalized or had surgery?</p> <p style="margin-left: 40px;">i. Why? _____</p> <p>6. Is your child experiencing any of the following behaviors/symptoms? Check all that apply</p> <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Anxiety</td> <td><input type="checkbox"/> School problems (behavioral, academic, social)</td> </tr> <tr> <td><input type="checkbox"/> Depressed mood</td> <td><input type="checkbox"/> Difficulty with peers</td> </tr> <tr> <td><input type="checkbox"/> Anger</td> <td><input type="checkbox"/> Self-injurious behaviors</td> </tr> <tr> <td><input type="checkbox"/> Difficulty with concentration</td> <td><input type="checkbox"/> Impulsivity</td> </tr> </table> <p style="margin-left: 40px;"><input type="checkbox"/> Other (please specify): _____</p> <p>7. <input type="checkbox"/> Yes <input type="checkbox"/> No Do you want your child to receive counseling services?</p>	<input type="checkbox"/> Anxiety	<input type="checkbox"/> School problems (behavioral, academic, social)	<input type="checkbox"/> Depressed mood	<input type="checkbox"/> Difficulty with peers	<input type="checkbox"/> Anger	<input type="checkbox"/> Self-injurious behaviors	<input type="checkbox"/> Difficulty with concentration	<input type="checkbox"/> Impulsivity
<input type="checkbox"/> Anxiety	<input type="checkbox"/> School problems (behavioral, academic, social)							
<input type="checkbox"/> Depressed mood	<input type="checkbox"/> Difficulty with peers							
<input type="checkbox"/> Anger	<input type="checkbox"/> Self-injurious behaviors							
<input type="checkbox"/> Difficulty with concentration	<input type="checkbox"/> Impulsivity							

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