Medical Enrollment Form

Questions or concerns? Call (475) 231-6978

SBHC School-Based Health Care

Community Health Center, Inc.

I give my child/self permission to obtain SCHOOL-BASED MEDICAL SERVICES while enrolled in a school serviced by Community Health Center, Inc. (CHC) or until I revoke permission. ❑ YES ❑ NO

All insurances will be billed at time of visit.

I certify that the health information provided is accurate to the best of my knowledge and understand that incorrect information can be dangerous to the student/patient's health. I will notify CHC of any changes to medical information. ❑ YES ❑ NO

I have reviewed CHC's Rights and Responsibilities Policy at sbhc1.com. ❑ YES ❑ NO

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION:

I authorize the release of any medical, dental or behavioral health information necessary to process my claim. I also authorize payment of health benefits to Community Health Center, Inc. for services provided.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES:

I understand that information regarding how CHC will use and disclose my information can be found in CHC's Notice of Privacy Practices and I have received a copy. In addition to the uses and disclosures detailed in the Notice of Privacy Practices, I agree to permit CHC to send text messages to my child (only for scheduling purposes) or to me if a cell phone number(s) is listed below.

AUTHORIZATION FOR EXCHANGE OF HEALTH & EDUCATION INFORMATION:

I hereby authorize CHC to exchange health and education records with my child's school district for the purpose of providing care and treatment to my child, if applicable, and/or to exchange physical exam and immunization information required by law. I recognize that health records if received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by Family Education Rights & Privacy Act.

How did you hear about our services? ❑ Internet ❑ Friend ❑ School ❑ Newsletter ❑ Other: _____

PATIENT INFORMATION

*** Required information.**

Full Legal Name (First/Middle/Last): _____

Address/Apt #: _____

City/State/ZIP: _____

Social Security Number: _____ DOB (MM/DD/YY): _____

Primary Language: _____ Sex: ❑ Male ❑ Female ❑ Undefined

Gender: ❑ None ❑ Identifies as Male ❑ Identifies as Female ❑ Female-to-Male ❑ Male-to-Female ❑ Neither exclusively Male nor Female, Genderqueer ❑ Other (Specify): _____ ❑ Choose not to disclose

School Patient Attends: _____ Grade: _____

Ethnicity: ❑ Hispanic ❑ Non-Hispanic

Race:

- ❑ Black or African American
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ White
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ Patient Declined
- ❑ State Prohibited
- ❑ Unspecified

Primary Care Provider's Name: _____

Phone Number: _____

Dentist's Name: _____

Phone Number: _____

For assistance applying for Medicaid/Husky or other insurance options, TEXT "help" to (860) 560-1398 and an Access to Care team member will contact you.

INSURANCE INFORMATION

*** Medical Insurance:** _____ *** Medicaid ID #:** _____ *** Private Ins. ID/Policy #:** _____ *** Group Number:** _____

*** Insurance Address:** _____ *** Insurance Phone Number:** _____ (info on back of card)

*** Policy Holder Name:** _____ *** Policy Holder DOB** (MM/DD/YY)**:** _____

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship to Patient: _____ DOB (MM/DD/YY): _____

*** Address/Apt #** (If different from above): _____ City: _____ ZIP: _____

I agree that messages can be left for me on: ❑ Home Phone ❑ Cell Phone ❑ Work Phone

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Student's Cell Phone: _____ Student's Email Address: _____ Email Address of Parent/Guardian: _____

EMERGENCY CONTACT (If different than Parent/Guardian)

Name: _____ Relationship to Patient: _____ Phone Number: _____

*** Signature of Parent/Legal Guardian or Student if over 18 years old:** _____

If not patient or parent, proof of legal authority must be provided.

*** Print Name:** _____ **Date:** _____

By signing above, I understand and acknowledge that I have read and understand this consent and I have received CHC's Notice of Privacy Practices currently in effect.

Student/Patient Medical History

Please contact CHC with any changes to this medical history.

Patient Name: _____ Date of Birth (MM/DD/YY): _____

MEDICAL HISTORY

Does the patient have any medical conditions?	❑ YES ❑ NO	Explain:
Does the patient take any medications? (including inhalers)	❑ YES ❑ NO	List all medications:
Has the patient had any serious injuries?	❑ YES ❑ NO	Explain:
Does the patient have a birth or heart defect or have history of a heart problem or surgery?	❑ YES ❑ NO	Explain:
Has the patient ever been hospitalized overnight?	❑ YES ❑ NO	Explain:
Has the patient had any surgery in the past?	❑ YES ❑ NO	Explain:
Has the patient had any shunts placed or has an indwelling catheter?	❑ YES ❑ NO	Explain:
Is/was the patient a teen parent?	❑ YES ❑ NO	
Is the patient pregnant or possibly pregnant?	❑ YES ❑ NO	Due date:
Is the patient currently nursing?	❑ YES ❑ NO	
Is premedication with antibiotics needed prior to dental procedures?	❑ YES ❑ NO	Explain:
Does the patient smoke or chew tobacco?	❑ YES ❑ NO	

Does the patient have or had any of these CONDITIONS?

Anemia/blood disorders	❑ YES ❑ NO	Pneumonia	❑ YES ❑ NO
Asthma	❑ YES ❑ NO	Rheumatic fever, heart disease, murmur	❑ YES ❑ NO
Autism	❑ YES ❑ NO	Scoliosis	❑ YES ❑ NO
Bladder or kidney infections	❑ YES ❑ NO	Seizures	❑ YES ❑ NO
Cancer/leukemia	❑ YES ❑ NO	Thyroid disease	❑ YES ❑ NO
Chicken pox	❑ YES ❑ NO	Tuberculosis	❑ YES ❑ NO
Diabetes	❑ YES ❑ NO	Ulcer/digestive problem	❑ YES ❑ NO
Eating issues	❑ YES ❑ NO	Any mental health issues?	❑ YES ❑ NO
Endocrine/gland disease/ autoimmune disease	❑ YES ❑ NO	Any birth or congenital defects (spina bifida, brain, heart, lung, etc.)?	❑ YES ❑ NO
Headaches/migraines	❑ YES ❑ NO	Any problems with teeth?	❑ YES ❑ NO
Hepatitis or liver problems	❑ YES ❑ NO	Any teeth causing pain?	❑ YES ❑ NO
Learning/developmental issues	❑ YES ❑ NO	Any bleeding when brushing or flossing?	❑ YES ❑ NO
Mononucleosis	❑ YES ❑ NO	Had a dental cleaning within the last 6 months?	❑ YES ❑ NO
Overweight/obesity	❑ YES ❑ NO	Other:	❑ YES ❑ NO

ALLERGIES

Any foods (including lactose intolerance)	❑ YES ❑ NO	Comment:
Any medications (including over the counter or antibiotics; penicillin or amoxicillin)	❑ YES ❑ NO	Comment:
Local anesthetics (including lidocaine) or latex	❑ YES ❑ NO	Comment:
Does the patient have an Epi-Pen at school?	❑ YES ❑ NO	Comment:
Other:		Comment: