# DEBACA FAMILY SCHOOL BASED HEALTH CLINIC

**PATIENT REGISTRATION AND CONSENT FOR SERVICES** | **FORT SUMNER SCHOOL BASED HEALTH CENTER** | **FY 13-14**

## STUDENT INFORMATION

| | | | |
|---|---|---|---|
| Patient Name (last, first, middle) | Date of Birth | Social Security Number<br>Student ID Number | Grade |
| Patient Address (street, city, state, and zip) | Patient Phone - home | | |
| | Patient Phone - Cell | | |
| Parent(s)/Legal Guardian(s) Name(s) | Patient Sex ☐ Male ☐ Female | | |
| | Patient Race ☐ Black ☐ White ☐ Native American/Alaska Native ☐ Hispanic ☐ Other | | |
| Parent(s)/Legal Guardian(s) Address (street, city, state and zip) | Home Phone | | |
| | Work Phone | | |
| | Cell Phone | | |
| Emergency Contact Person Name and Relationship to Patient | Emergency Phone - Home | | |
| | Emergency Phone - Cell | | |
| | Emergency Phone Work | | |

## INSURANCE INFORMATION

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|---|---|
| Primary Care Physician | Primary Care Physician Phone Number |
| Primary Care Physician Address | |
| Name of Health Insurance (If no insurance coverage, please enter N/A) | Medicaid coverage ☐ Yes ☐ No<br>Blue Cross/Blue Shield Salud ☐ United Salud ☐ Molina Salud ☐ Presbyterian Salud ☐ Fee-For-Service |
| Policy Number | Medicaid Number: |
| Name of Policy Holder | Relationship to Patient |

## HEALTH HISTORY

| List any allergies | List any surgeries When/Where | List Hospitalizations When/Where | List Current Medications/ Dosages |
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List any family health conditions which may be inherited (i.e. high blood pressure, heart disease):

## CONSENT FOR SERVICES

I give permission for my child, named above, to receive SBHC services while he/she is enrolled in this school and for SBHC staff to access my child's class schedule (for appointment purposes only). I understand that SBHC services are confidential, except in a life-threatening situation or when emergency services are needed and in accordance with the law. I give permission to the SBHC to exchange pertinent information to appropriate persons for the purpose of providing healthcare, diagnosis, treatment and counseling services, as well as for maintaining quality and safety. I understand that SBHC health records are confidential and will not be shared unless written consent is provided by the student and/or parent/guardian. I have received a copy of the the HIPAA Notice of Privacy Practices. I understand that New Mexico law does not require parental consent for treatment or advice about sexually transmitted diseases, pregnancy or contraception to minors under 18 years of age and behavioral health counseling services to minors age 14 years or older. THE FORT SUMNER SCHOOL BOARD OF EDUCATION HAS NOT APPROVED FAMILY PLANNING SERVICES (CONTRACEPTION) AT THE SCHOOL BASED CLINIC. **Unless I choose to withdraw my consent in writing, this authorization will continue for the entire period of time my child is enrolled in this school.**

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| Signature of Parent/Guardian | Date |
| Signature of patient, if 18 years or older | Date |

**Please read the important information on the back of this form.**

Revised March 2013