PATIENT REGISTRATION & CONSENT FOR SBHC SERVICES	LAS CLINICAS DEL NORTE SCHOOL BASED HEALTH CENTER (SBHC)		FY 14-15

STUDENT INFORMATION

Student Name (last, first, middle)	Date of Birth	Social Security 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 Numbers
Emergency Contact Person Name and Relationship to Patient	Emergency Phone

INSURANCE INFORMATION

Primary Care Giver:	Dental Care Provider/ Last Visit Date
Medical Insurance: Policy Number: Name of Policy Holder: Relationship to Patient:	Dental Insurance: Policy Number: Name of Policy Holder: Policy Holder's Date of Birth: Policy Holder's SS#:

If Medicaid coverage, please check type:

☐ Blue Cross/Blue Shield Centennial Care ☐ United Heath Care Centennial ☐ Molina Centennial Care ☐ Presbyterian Centennial Care ☐ Full Medicaid

CONSENT FOR SERVICES

I give Permission for SBHC Staff to Administer the following Over the Counter Medecines. PLEASE INITIAL

_____TYLENOL _____TUMS _____ALLERGY MEDS _____IBUPROFEN _____MYLANTA _____DECONGESTANTS

Check here if you **DO NOT** want your child to participate in**:** _____**Dental Screening** _____ **BMI Screening**

I give permission for my child, named above, to receive services at the School Based Health Center (SBHC) to include medical, dental, and behavioral health services and for Las Clinicas del Norte (LCDN) SBHC staff to access my child's school record. I also give permission for the SBHC staff to consult with and provide information and records to other medical/dental care and mental health providers, including school health professionals, and for purposes of program evaluation and quality assurance. I understand that health records are confidential and will not be open to the school or other outside personnel unless the parent/guardian gives written consent, or in the case of treatment for which the minor has given consent, unless the minor gives written consent. I have received a copy of LCDN's notice of privacy. I also 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.

I hereby authorize LCDN to bill my insurance. I authorize payment directly to LCDN of all insurance benefits otherwise payable to me for services rendered to my dependents. I authorize LCDN to release any information concerning my dependent's illness and treatment, including conveyance of such information by electronic means, required to secure payment of benefits. I authorize the use of this signature on all insurance submissions. **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.**

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

Revised July 2014

Patient I

Patient's Name	**Patient's Date of Birth**

Medications:	
Hospitalizations:	
Surgeries:	

List any family health conditions which may be inherited (i.e. high blood pressure, heart disease):

Please List

Is patient allergic to or have you had any reactions to the following:

	YES	NO
Local Anesthitics (e.g. Novocain)	☐	☐
Penicillin or other antibiotics, aspirin	☐	☐
Barbituates	☐	☐
Sulfa Drugs	☐	☐
Any other Allergies? If yes, please list _____	☐	☐

Patient Medical History

Does your child have any of the following?

	YES	NO		YES	NO
High Blood Pressure	☐	☐	Cancer	☐	☐
Heart Attack	☐	☐	Arthritis	☐	☐
Rheumatic Fever	☐	☐	Joint Replacement or Implant	☐	☐
Swollen Ankles	☐	☐	Hepatitis / Jaundice	☐	☐
Fainting/ Seizures	☐	☐	Sexually Transmitted Disease	☐	☐
Asthma	☐	☐	Stomach Troubles / Ulcers	☐	☐
Low Blood Pressure	☐	☐	Chest Pains	☐	☐
Epilepsy / Convulsions	☐	☐	Easily Winded	☐	☐
Leukemia	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Hay Fever / Allergies	☐	☐
Kidney Diseases	☐	☐	Tuberculosis	☐	☐
AIDS or HIV Infection	☐	☐	Radiation Therapy	☐	☐
Thyroid Problem	☐	☐	Glaucoma	☐	☐
Heart Disease	☐	☐	Recent Weight Loss	☐	☐
Cardiac Pacemaker	☐	☐	Liver Disease	☐	☐
Heart Murmur	☐	☐	Heart Trouble	☐	☐
Angina	☐	☐	Respiratory Problems	☐	☐
Emphysema	☐	☐	Other _____	☐	☐
Frequently Tired	☐	☐	Use Contact lenses?	☐	☐
Anemia	☐	☐			

Consent For Services

In case of an emergency involving my child and I cannot be reached,I hereby give consent to the Mesa Vista School District to arrange transportation for my child which may include to Las Clinicas del Norte Community Health Clinic. I authorize these providers to give reasonable and customary medial and health care deemed necessary. If for any reason the named above cannot provide the type of care my child needs, I authorize approporate transportation (by ambulance) and medical care of my child to a hospital or medical facilty. This authorization does not cover major surgery unless one other doctor/dentist agrees to the need. Nothing in this secion shall be construed to imose liability on any school official, school employee, or Las Clinicas del Norte employee, who in good faith, attepts to comply with this section. It is understood that I will be financially responsible for all emergency care.

Signature of Parent/Guardian _____Date_____

Signature of patient if 18 years or older_____Date_____