

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 <input type="checkbox"/> Male <input type="checkbox"/> Female		
		Patient Race <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native American/Alaska Native <input type="checkbox"/> Hispanic <input type="checkbox"/> 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:	Dental Insurance:		
	Policy Number:	Policy Number:		
	Name of Policy Holder:	Name of Policy Holder:		
Relationship to Patient:	Policy Holder's Date of Birth:			
	Policy Holder's SS#:			
If Medicaid coverage, please check type:				
<input type="checkbox"/> Blue Cross/Blue Shield Centennial Care <input type="checkbox"/> United Heath Care Centennial <input type="checkbox"/> Molina Centennial Care <input type="checkbox"/> Presbyterian Centennial Care <input type="checkbox"/> 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			
	<p>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.</p> <p>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.</p>			
Signature of Parent/Guardian			Date	
Signature of patient, if 18 years or older			Date	

Patient	Patient's Name	Patient's Date of Birth				
Patient	Medications:					
	Hospitalizations:					
	Surgeries:					
	List any family health conditions which may be inherited (i.e. high blood pressure, heart disease):					
	Please List					
Patient Medical History	Is patient allergic to or have you had any reactions to the following:		YES	NO		
	Local Anesthetics (e.g. Novocain)		<input type="checkbox"/>	<input type="checkbox"/>		
	Penicillin or other antibiotics, aspirin		<input type="checkbox"/>	<input type="checkbox"/>		
	Barbituates		<input type="checkbox"/>	<input type="checkbox"/>		
	Sulfa Drugs		<input type="checkbox"/>	<input type="checkbox"/>		
	Any other Allergies? If yes, please list _____		<input type="checkbox"/>	<input type="checkbox"/>		
	Does your child have any of the following?					
		YES	NO	YES	NO	
	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant
	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice
	Fainting/ Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease
	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles / Ulcers
	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains
	Epilepsy / Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded
	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies
	Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
	AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	
Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use Contact lenses?	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
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 appropriate transportation (by ambulance) and medical care of my child to a hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist agrees to the need. Nothing in this section shall be construed to impose liability on any school official, school employee, or Las Clinicas del Norte employee, who in good faith, attempts 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 _____			