GEORGE RICKS SCHOOL BASED HEALTH CENTER REGISTRATION FORM

Patient Information

Full name:____Date:____________________________

Social security number:________________________Date of birth:____________________Gender: ☐Male ☐Female

Address: ____

City:___________________________County:______________________State:_________ Zip: _____________

Phone:__________________________________ Alternate number: ________________________________

School:_______________________________Grade:__________Teacher:___________________________

Ethnicity: ☐Caucasian ☐Hispanic ☐African-American ☐Asian Other: _______________________________________

Primary language: ☐English ☐Spanish Other: ____

Household Information

Mother/guardian's name:___________________________________Relationship:_________________________

Social security number:____________________________________Date of birth: ________________________

Father/guardian's name:__________________________________ Relationship: ________________________

Social security number:____________________________________Date of birth: ________________________

Parent's marital status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widow/Widower

Parent's work status: ☐Full-time ☐Part-time ☐Retired ☐Unemployed

Insurance Information

Does your child have any of the following type of insurance coverage? *Please check all that apply*:

Medicaid ☐Yes ☐No Medical insurance ☐Yes ☐No CHIP ☐Yes ☐No Dental insurance ☐Yes ☐No

Preferred pharmacy: ____

If the child is receiving Medicaid, CHIP or does not have insurance, please provide the following information:

Estimated annual gross income: $_______________________Number of people in household: _________________

Social History

Who lives in the household? Members in the household (please list names and relationship):

____ ____

____ ____

____ ____

Smokers in the household? ☐Yes ☐No If yes, ☐Indoor ☐Outdoor

Child's Medical History

Is your child allergic to latex? ☐Yes ☐No

Does your child have food or drug allergies? ☐Yes ☐No If yes, specify: _______________________________________

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Were there any problems with mother's pregnancy with this child? ☐Yes ☐No

If yes, please explain: ______________________________

Child's birth: ☐Term delivery ☐Premature birth Weight:____________ Birth complications: ______________________________

Child hospitalizations: ☐Yes ☐No If yes, diagnosis and dates: ______________________________

Child surgeries: ☐Yes ☐No If yes, types and dates: ______________________________

Child's Chronic Health Problems

Rheumatic fever	☐Yes ☐No	Skin	☐Yes ☐No	Trauma	☐Yes ☐No
Gastrointestinal	☐Yes ☐No	Hepatitis	☐Yes ☐No	Asthma/Bronchitis	☐Yes ☐No
Genetic syndrome	☐Yes ☐No	Urinary	☐Yes ☐No	Seizures	☐Yes ☐No
Ear infections	☐Yes ☐No	Dental	☐Yes ☐No	ADD/ADHD	☐Yes ☐No
Visual	☐Yes ☐No	Hearing	☐Yes ☐No	Developmental	☐Yes ☐No
Anemia	☐Yes ☐No	Bleeding	☐Yes ☐No	Heart	☐Yes ☐No
Allergies/Sinus	☐Yes ☐No	Cancer	☐Yes ☐No	Infectious disease	☐Yes ☐No
Diabetes	☐Yes ☐No	Orthopedic (broken bones)	☐Yes ☐No	Mental health issues	☐Yes ☐No

Other:______________________________

Explain all marked answers:

____

____

Current medication (name/dose):

____

____

Family Medical History (siblings, parents, grandparents)

Heart disease	☐Yes ☐No	Asthma	☐Yes ☐No	Kidney disease	☐Yes ☐No
High blood pressure	☐Yes ☐No	Seizures	☐Yes ☐No	Diabetes	☐Yes ☐No
Mental health issues	☐Yes ☐No				
Cancer	☐Yes ☐No	If yes, please specify type of cancer: ______________________________			

Other: ______________________________

Signature

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal guardian signature:______________________________ Date: ______________

Reviewed by:______________________________ Date: ______________
To be completed by Methodist Healthcare Ministries staff or personnel.

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Consent for George Ricks School-Based Treatment, Services and Communication

Date: ___________ **Patient's Name**: ___________________________ **Date of Birth**: ____________

I give permission to Methodist Healthcare Ministries of South Texas, Inc. (MHM) to provide my child the services checked below:

I authorize MHM's George Ricks School Based Health Center to provide:

☐ Yes ☐ No Medical Services
☐ Yes ☐ No Dental Services
☐ Yes ☐ No Social Services
☐ Yes ☐ No Counseling

I authorize MHM to pull my child out of class with scheduled appointment

☐ Yes ☐ No Medical Services
☐ Yes ☐ No Dental Services
☐ Yes ☐ No Social Services
☐ Yes ☐ No Counseling

I authorize MHM's George Ricks School Based Health Center Providers to release information to:

☐ Yes ☐ No The school **athletic program** (sport's physical form only)
☐ Yes ☐ No The school nurse

Consent for Communication

I ☐ **Do NOT consent** to MHM contacting me for appointment scheduling, appointment reminders, virtual appointments, and other wellness promotion reasons.

I ☐ **Do consent** to MHM contacting me for appointment scheduling, appointment reminders, virtual appointments, and other wellness promotion reasons. I understand that I may be contacted by an MHM team member or an Automated Telephone Dialing System (ATDS).

☐**Non-Cellular (landline) Telephone**
The non-cellular telephone number that I authorize to receive
☐**Voice Messages**
is: (___)____-____

☐**Cellular Telephone** - standard text messaging rates may apply as provided in your wireless plan.
The cellular telephone number that I authorize to receive
☐**Voice Messages** ☐**Text Messages**
is: (___)____-____

I understand that text messages are sent over a public network to a personal telephone and may not be secure. However, I am aware that MHM will not transmit any information which would enable me to be identified.

☐**The EMAIL** that I authorize to receive messages is:

____________________________________@__________________________

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Privacy Practices

I understand that my medical records are kept electronically. At times, Methodist Healthcare Ministries of South Texas, Inc. (MHM) might share my medical information with other parties involved in my care for the purposes of:

- Treatment (example: two doctors working together in my treatment)
- Health operations-to improve the services that MHM provides

I can find more information about this in the Notice of Privacy Practices on MHM.org.

☐ **I have received a copy of the Notice of Privacy Practices.**

Rights and Responsibilities

☐ **I have received information about my rights and responsibilities as a patient/client of Methodist Healthcare Ministries.**

This consent form has been explained to me. I understand what I am consenting to. I further understand that I may revoke this authorization at any time.

Health Information Exchange (HIE)

MHM submits healthcare information to Health Information Exchanges (HIE), which helps us provide better care by:

- Coordinating care/services with other providers and hospitals to prevent gaps in your care

Your medical information will be provided to one or more Health Information Exchanges. If you choose not to participate in the Health Information Exchange, you can do so by checking the box below. You will still qualify for MHM services.

☐ **No, I do not want my medical information shared with any Health Information Exchange.**

Patient's /Client's Signature: ________________________________ Date: _______________

Parent/Guardian Signature__________________________________ Date: _______________

Relationship to the Patient/Client: ____