

Thundermist Health Center- Woonsocket SBHC Patient Registration

SECTION A: PATIENT INFORMATION: Please complete for your child.

Patient Last Name _____ Patient First Name _____ Middle Initial _____

Preferred Name _____ Pronouns (she/her, he/him) _____

Address _____ Home Phone _____
(Street) (City/State) (Zip Code)

Cell Phone _____ Date of Birth _____ Age _____ SSN# _____

Sex: Male Female Other Gender (all that apply): Boy Girl Transgender Other _____

Patient E-mail: _____ Parent/Guardian E-mail: _____

Besides a parent or guardian, who else may we contact in an emergency? _____
(Name) (Phone) (Relationship to patient)

Primary Care Provider's Name (regular doctor) _____ Primary Care Provider Phone Number _____

Pharmacy Name and Address _____ Regular Dentist's Name _____

Does your child have any allergies, including to latex? Yes No If yes, to what? _____

Is your child on any medication, including over the counter Yes No If yes, what kind and for what medical problem _____

Does your child have any health problems or hospitalizations? Yes No If yes, what? _____

Has your child ever had a reaction to medication? Yes No If yes, what happened? _____

Please list any special needs your child has (physical, emotional, cultural, religious or learning styles/preferences)

I have read the attached parent notification form and my child may receive the following services at the Health Hut: (Please check each service)

Medical Services (as outlined in Health Hut Handbook)	Yes <input type="radio"/>	No <input type="radio"/>	
Nutritional Counseling	Yes <input type="radio"/>	No <input type="radio"/>	
Behavioral Health Services and Counseling	Yes <input type="radio"/>	No <input type="radio"/>	
Dental Services	Yes <input type="radio"/>	No <input type="radio"/>	If yes, date of last dental visit:
Birth Control	Yes <input type="radio"/>	No <input type="radio"/>	

SECTION B: FAMILY INFORMATION: Please complete below for the custodial parent/guardian

Parent/Guardian _____ SS# _____
(Last) (First) (Middle)

Address _____ Date of Birth _____
(Street) (City/Town) (State) (Zip Code)

Home Phone _____ Work Phone _____ Cell: _____ Employer _____
(Name) (Address)

SECTION C: INSURANCE COVERAGE: if you have no medical/dental insurance, please write none.

Please list ALL medical and dental insurance coverage for the patient including Medicaid, Medicare, Rite Care and private insurance.

1. Name of Insurance _____ Policy/ID Number _____

Whose name is the insurance in? _____ the patient _____ the parent or spouse in Section B above
Other: Name _____ Date of Birth _____ SS# _____
Relationship to Patient _____

2. Name of Insurance _____ Policy/ID Number _____

Whose name is the insurance in? _____ the patient _____ the parent or spouse in Section B above
Other: Name _____ Date of Birth _____ SS# _____
Relationship to Patient _____

OVER FOR SIGNATURE

Office Use Only: Medical Hx Reviewed _____ Patient will continue medications as described above Y N (If no, exceptions in MR). Date _____

SECTION D: FINANCIAL INFORMATION: Information is optional, but helpful to us when we file reports for various grants. (All financial information is held strictly confidential and is not disclosed by the patient's name to any outside source.)

Total FAMILY income from ALL SOURCES: \$_____ **CIRCLE ONE:** Annual Monthly Weekly Other
(Income sources include employment, public assistance, child support, alimony, etc.) Number in family_____

SECTION E: OTHER INFORMATION – Thundermist must provide its State and Federal Funders with certain information about the patients we are serving. We would appreciate it if you would complete this section. All information is kept strictly confidential and used for statistical group reports only.

Ethnicity: (check one) Hispanic Non-Hispanic Choose not to report

Race :(check one) Asian White Black or African American American Indian or Alaskan Native Native Hawaiian Other Pacific Island Other More than one race

Primary language spoken in your home: English Spanish Laotian Other _____

SECTION F: CONSENT AND SIGNATURE Please sign below. Parent/Guardian must sign for minor children.

ALL PATIENTS: This Section must be completely filled out for you/your child to receive services at the Health Hut. I certify that I am presenting myself/my child for services provided by Thundermist. I give Thundermist and its staff my permission to: (a) use any information contained in my (my child's) records in order to process requests for payment from my medical or dental insurance company; and (b) disclose any information contained in my (my child's) records to representatives from the Woonsocket Education Department for the purposes of scheduling services or coordinating care. I also give the Woonsocket Education Department permission to share my/my child's relevant information with Thundermist. Thundermist will maintain strict confidentiality with regards to all information about me/my child, according to all applicable State and Federal laws, and Thundermist policies. I understand that my/my child's medical records are the property of Thundermist and will not be released without my express written consent except in those circumstances permitted by law or to the Woonsocket Education Department as provided above. I have received a copy of the Health Hut Patient Handbook which includes Patient Rights and Responsibilities. I understand that I may ask staff for assistance if I have any questions about these policies. I understand that a copy of a visit note will be provided to my/my child's primary care provider when seen for medical services and may be provided to my/my child's dentist when seen for dental services. I hereby acknowledge that I have received a copy of Thundermist Health Center's Notice of Privacy Practices. I authorize Thundermist staff to provide me (my child) reasonable and proper care by today's standards. A copy of the signature below is as valid as the original and remains in effect until my child is no longer enrolled as a student in the Woonsocket school system.

X _____

Signature of Parent/Guardian/Student if 18 or Older

_____ **Date**

If you marked "Yes" to Dental previously, your child will automatically be scheduled to receive an examination, cleaning, fluoride treatment, x-rays, and sealants if required. You must fill out the following information if you want your child to receive dental services.

Asthma Tuberculosis Seizure/Epilepsy Mental Health/Behavioral issues Hepatitis Kidney Disease
Diabetes ADD/ADHD Bleeding Disorder Heart Murmur/Mitral Valve Prolapse Heart Defect/Heart Transplant
Rheumatic Fever

Is your child allergic to: Aspirin Iodine Penicillin/other antibiotic Latex Local Anesthetic
Other _____

Does the child: Have problems with gums bleeding with flossing? Yes No Use tobacco products? Yes No
Have teeth that are causing pain? Yes No Have fear of dental care? Yes No

Females only: Taking birth control? Yes No Pregnant (or think may be pregnant) Yes No Nursing? Yes No

Thundermist also offers birth control services at the Health Hut. We encourage adolescents to involve their parents or other trusted adults in these decisions. We also promote abstinence, but it is the policy of the Health Hut to distribute birth control methods only with parental consent.

I give consent for my son/daughter to receive access to birth control as described in the Health Hut Handbook.

X _____

Signature of Parent/Guardian/Student if 18 or Older

_____ **Date**