Thundermist Health Center- West Warwick 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 ❍	No ❍
Nutritional Counseling	Yes ❍	No ❍
Behavioral Health Services and Counseling	Yes ❍	No ❍
Dental Services	Yes ❍	No ❍ If yes, date of last dental visit:

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

Parent/Guardian____ SS# __________________________
(circle one) (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 West Warwick Public Schools for the purposes of scheduling services or coordinating care. I also give the West Warwick Public Schools 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 West Warwick Public Schools 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 West Warwick School District.

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❍