

# Thundermist Health Center - Woonsocket SBHC Patient Registration

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**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 and/or Thundermist Health Center:

(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 (High School Students)	Yes <input type="radio"/>	No <input type="radio"/>

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  Seizure/Epilepsy  Mental Health/Behavioral issues  Diabetes  Bleeding Disorder  Heart Valve Replacement 

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**SECTION B: FAMILY INFORMATION:** Please complete below for the custodial parent/guardianParent/Guardian \_\_\_\_\_ SS# \_\_\_\_\_  
(Last) (First) (Middle)Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Street) (City/Town) (State) (Zip Code)Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell: \_\_\_\_\_ Employer \_\_\_\_\_  
(Name) (Address)

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**SECTION C: 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 and/or at Thundermist Health Center. 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**