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 and/or Thundermist Health Center:
(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:
Birth Control	Yes ❍	No ❍	

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: 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.

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 ❍

X_____ _____

Signature of Parent/Guardian/Student if 18 or Older **Date**