G. A. Carmichael Family Health Center
School-Based Registration Form

☐New Student ☐Existing Student

Legal Name:_____
Last First Middle Name

Date of Birth (mm/dd/yy) __/_____/_____ **Social Security #**___-___-_____ **Mother's Maiden Name:** _____

Student's Contact Information

Mailing Address: _____ **City:** _____**State**_____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____ **Email Address:** _____ **Communication Preferences:** _____

Okay to leave a voicemail? ☐Yes ☐No

Okay to leave a voicemail? ☐Yes ☐No

Okay to leave a voice mail? ☐Yes ☐ No

Would you like to sign up for the Patient Portal? ☐Yes ☐ No

Communication Preferences: Check all that apply:
☐Mail
☐Email
☐Patient portal
☐Primary phone

Students Emergency Contact

Name
_____
Phone Number
_____
Relationship to Student
_____
Name
_____
Phone Number
_____
Relationship to Student
_____

Student Preferred Language

☐ English
☐ French
☐ Vietnamese
☐ Need an Interpreter
☐Other_____
☐Japanese
☐Chinese
☐ Korean
☐ Spanish

Students Preferred Pharmacy

Pharmacy Name:
_____
Pharmacy Address
_____
Pharmacy Phone
_____

Student Demographic Information

Marital Status:
☐Married
☐Single
☐Separated
☐Partnered
☐Divorced

Race:
☐Widow
☐Black/African American
☐Hispanic
☐Pacific Islander
☐American Indian/Alaskan Native
☐White
☐Asian
☐Native Hawaiian

Ethnicity:
☐More than one race
☐Other
☐Hispanic or Latino
☐Not Hispanic or Latino

Gender:
☐Unknown
☐Decline to specify
☐Other
☐Male
☐Female

Student School Name & Grade

School Name:
_____
Grade_____

Income
☐$0-$14,580
☐$14,581-$19,720
☐$19,721-$24,860
☐$24,861-$30,000
☐$30,001-$35,140
☐$35,141-$40,280
☐$40,281-$45,420
☐$45,421-$50,560
☐$50,561-$99,999

Household Size _____
Number of people in household____

*ALL FAMILY MEMBERS THE AGE OF 21 LISTED ABOVE MUST PRESENT INCOME OR A NOTARIZED LETTE STATING HE/SHE HAS NO INCOME AND

Insurance Information: What Health Insurance Coverage Do You Have? Please check all that apply.
☐Medicaid ☐ Medicare ☐ Private Health Insurance ☐ Dental ☐Uninsured

Primary Insurance Name: _____ **Policy Number:** _____ **Group#:** _____
Medicaid Number: _____ **Medicare Number:** _____

Parent or Legal Guardian Information and Consent

Parent or Guardian _____ **Phone #** _____ **Social Security #**_____ **Birth Date** _____
☐Yes, I would like my child to be assessed and treated for medical and dental services by G. A. Carmichael Family Health Center.

☐ **No, I would not like my child to be assessed and treated for medical and dental services by G. A. Carmichael Family Health Center.**
Signature of Parent or Legal Guardian: _____ Date: _____
Please list any medications your child is taking:
Is your child's immunization record current and up to date? □ Yes or □ No

Family Health History: Does anyone in your child's family have the following? Check all that apply.

☐ **Heart Attach**
☐ **Health Disease**
☐ **High Blood Pressure**
☐ **Stroke**
☐ **Cancer**
☐ **Diabetes**
☐ **Nervous/Mental Health Problems**
☐ **Kidney Disease**
☐ **Seizures Disorder**
☐ **Sudden Death**
☐ **Sickle Cell Anemia**

Child Health History: Does your Child's Family Have the following? Check all that apply.

☐ **Chicken Pox**
☐ **Asthma**
☐ **Communicable Disease**
☐ **Meningitis/Encephalitis**
☐ **Tonsillitis**
☐ **High Blood Pressure**
☐ **Heart Disease/Heart Murmur**
☐ **Respiratory Disease**
☐ **Kidney Disease**
☐ **Thyroid Disease**
☐ **Seizures (fits/convulsions)**
☐ **Major Injuries**
☐ **Behavior Programs**
☐ **Speech Problems**
☐ **Diabetes**
☐ **Birth Defects**
☐ **Sickle Cell Disease**
☐ **Sickle Cell Trait**
☐ **Eating Problems**
☐ **Allergy to Novocain or Dental**
☐ **Anesthesia**
☐ **Food or Drug Allergy**
☐ **List_____**

ACKNOWLEDGEMENT OF RECEIPT OF G. A. CARMICHAEL FAMILY HEALTH CENTER NOTICE OF PRIVACY PRACTICES
I acknowledge that I have received a copy of the G.A Carmichael Family Health Center notice of privacy practices

PRINT NAME: _____ DATE: _____

SIGNATURE: _____

GENERAL CONSENT FOR INSURANCE, DIAGNOSIS AND TREATMENT

I, the patient or parent/ guarantor, hereby authorize any holder of information about me or any information needed for settlement of claims to be released to Medicaid, Medicare, or the Insurance Provider. I understand approved claims will be deducted from my allocated benefits whether they were rendered in one of our clinics or mobile health family. I request that all health insurance benefit payments be made on my behalf to G.A Carmichael Family Health Center (GACFHC), I understand that GACFHC will not be responsible for hospitalization charges, nor will it be responsible for other services rendered outside of GACFHC. I grant permission for GACFHC to furnish the patient records, requested information, or excerpts to medical service centers, third-party payers (for billing purposes), and requisite legal health or social services facilities. Permission is hereby granted to release medical records to the GACFHC from any and all hospitals, clinics, and physicians from which I have received medical/dental care.

Having registered with GACFHC, I, the undersigned patient or responsible person, understand that this registration form is valid, and services will continue as long as my child or I am enrolled in this school or until I decide to opt-out by sending a written notice to discontinue services. My signature is my authorization to bill on my behalf. My signature also serves as authorization for service and treatment. I may provide a written notice to dismiss this authorization to G.A. Carmichael Family Health Center at any time. I understand that G.A. Carmichael Family Health Center will be providing Early Periodic Screening. Diagnostic and Treatment Services (EPSDT), Medical Services, and Dental Services for children and adolescents through our School-Based clinics. Screenings include the following services:

- **Complete Physical Assessments (including sports physicals)**
- **Vision and Hearing Screenings; Wellness screening labs (as indicated for age)**
- **Dental Assessments, Treatment, and Referrals**
- **Developmental and Behavioral Screenings and Evaluations and Depression Screenings (age specified)**
- **Parent and Child Health Education**
- **Referrals for Health Services**

PRINT PARENT/ GUARDIAN NAME: _____ CHILD'S NAME: _____

PARENT/ GUARDIAN SIGNATURE: _____ DATE: _____

CONSENT FOR COVID-19 VACCINE: _____ DATE: _____

GACFHC SIGNATURE: _____ DATE: _____