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

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
____

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
☐Divorced
☐Widow

Race:
☐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:
☐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** _________

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 Attack
☐Heart Disease
☐High Blood Pressure
☐Stroke
☐Cancer
☐Diabetes
☐Nervous/Mental Health Problems
☐Kidney Disease

G. A. CARMICHAEL FAMILY HEALTH CENTER PUT YOUR FAMILY'S HEALTH IN OUR HANDS

☐ Seizures Disorder
☐ Sudden Death

☐ Sickle Cell Anemia

Child Health History: Does your child 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 any medications your child is taking ___________________________

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 G.A. Carmichael Family Health Center (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 authorizes billing on my behalf, as well as authorization for service and treatment. I may provide 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, Dental Services, and Wellness Exams for children and adolescents through our School-Based Clinics. Wellness exams include a comprehensive assessment of overall health and are designed to detect potential health issues early. The screenings provided through our clinics include:

- ☐ **Wellness screening labs and bloodwork (as indicated for age), Vision and Hearing Screenings,**
- ☐ **Sick Visit Only**
- ☐ **Complete Physical Assessments (including sports physicals)**
- ☐ **Vision and Hearing Screenings, Wellness screening labs, and bloodwork (as indicated for age)**
- ☐ **Dental Assessments, Treatment, and Referrals**
- ☐ **Developmental and Behavioral Screenings and Evaluations, including depression screenings (age-specific)**
- ☐ **Parent and Child Health Education**
- ☐ **Referrals for Health Services**

☐ **No, I would not like for my child to treated by GA for medical or dental services**

PRINT PARENT/ GUARDIAN NAME: ______________________________ **CHILD'S NAME:** ____________________

PARENT/ GUARDIAN SIGNATURE: ___________________________________ **DATE:** ____________________

CONSENT FOR COVID-19 VACCINE: ______________________________ **DATE:** __________________

GACFHC SIGNATURE: ____ **DATE:** ___________________