

Region 9 School Based Health Center

PATIENT REGISTRATION AND CONSENT FOR SERVICES				SY 26-27
STUDENT INFORMATION	Patient Name (last, first, middle)		Patient Preferred Name	Date of Birth
	Patient Address (street, city, state, and zip)		Patient Phone	Patient Email Address
	Parent(s)/Legal Guardian(s) Name(s)		Patient Sex at Birth (circle one) Male Female Intersex	
			Patient Race (circle one) Black Native American/Alaska Native Hispanic White Other	
	Parent(s)/Legal Guardian(s) Address (street, city, state and zip)		Parent/Guardian Phone	Parent/Guardian Email Address
	Emergency Contact Person Name and Relationship to Patient		Emergency Phone	
INSURANCE INFORMATION	Primary Care Physician		Primary Care Physician Phone Number	
	Primary Care Physician Address			
	Does the patient have Medicaid? YES NO If Yes, please circle provider below.			
	<div style="display: flex; justify-content: space-around;"> Blue Cross/Blue Shield United Healthcare New Mexico Medicaid Presbyterian Terquoise Molina Healthcare </div>			
	Medicaid Number:			
HEALTH HISTORY	List any allergies	List any surgeries When/Where	List Hospitalizations When/Where	List Current Medications/ Dosages
	List any family health conditions which may be inherited (i.e. high blood pressure, heart disease):			
PARENT/GUARDIAN CONSENT	Please initial on each line below to signify your acknowledgement of each item. Please sign below to consent to all services listed below.			
	<div style="display: flex;"> <div style="flex: 1;"> <p>_____ --I give permission for the patient named above to receive SBHC Telemedicine Program services including but not limited to assessment and testing performed by the school nurse and virtual evaluation by a licensed physical health provider.</p> <p>_____ -- I give permission for the above named patient to be seen via telemedicine and understand the risks of telemedicine listed here:</p> <ul style="list-style-type: none"> -Technical issues may interrupt or limit the visit. -The healthcare provider may not be able to fully assess the student without a hands-on examination. <p>_____ -Additional in-person evaluation, testing, or treatment may be necessary.</p> <p>_____ -As with any electronic communication, there is a small risk of unauthorized access to private health information despite safeguards.</p> <p>_____ --I understand that health records are confidential and will not be open to the school personnel unless the parent/guardian gives written consent.</p> <p>_____ --I hereby acknowledge that I can view a copy of the Region 9 School Based Health Center's Notice of Privacy Practices at www.r9sbhc.org or request a copy at the clinic located on the campus of Ruidoso High School.</p> </div> <div style="flex: 1; border-left: 1px solid black; padding-left: 10px;"> <p>_____</p> </div> </div>			
	Signature of Parent/Guardian		Date	
	Signature of patient, if 18 years or older		Date	