DE BACA FAMILY PRACTICE CLINIC

SCHOOL BASED HEALTH CENTER PATIENT REGISTRATION AND CONSENT — SY 2019-20

STUDENT INFORMATION

Patient Name (last, first, middle)	Mailing Address (city, state, zip)	Social Security No.
		Date of Birth
Parent(s)/Legal Guardian(s) Name(s)	Parent/Guardian Cell	Grade
	Parent/Guardian Work Number	
Emergency Contact Name & Relationship		Home Phone
	Emergency Contact Phone Number	
		Sex ☐ Male ☐ Female
Ethnicity ☐ Hispanic ☐ Non-Hispanic	Patient Race *(circle all that apply)* White African American Asian Native American/Alaska Native Native Hawaiian Other Pacific Islander	

MEDICAL INFO

Primary Care Physican	
Phone Number	
Name of Medical Health Insurance	
Policy Number	
Relationship to Patient	

DENTAL INFO

Primary Dental Provider
Phone Number
Name of Dental Insurance
Policy Number
Relationship to Patient

HEALTH HISTORY

Current Medication & Dosage *(including over the counter)*	**List ALL Allergies** *(including food/enviromental)*	**Surgeries/Hospitalizations**
☐ None	☐ None	☐ None

DEMOGRAPHIC INFO

Sexual Orientation: *(please circle)*	**Gender Identity:** *(please circle)*	**Would you like to receive a reminder that your child is due for immunizations?**
Straight (Not Lesbian/Gay)	Male	☐ Yes ☐ No
Lesbian/Gay	Female	
Bisexual	Transgender Male/Female-Male	
Something Else	Transgender Female/Male-Female	**Prefered Method of Communication**
Don't Know	Other	☐ English ☐ Spanish ☐ Other_____
Choose not to disclose	Choose not to disclose	

THE FOLLOWING INFORMATION IS GATHERED FOR NUMBER REPORTING PURPOSES ONLY.

If you would like to meet with our Insurance Guide about options available to you, please let us know.

Estimated Annual Income For Your Household *(circle one)*

Household Size:_____

Less than $12,000	$24,001 - $30,000	$42,001 - $48,000	
$12,001 - $18,000	$30,001 - $36,000	$48,001 - $54,000	More than $60,000
$18,001 - $24,000	$36,001 - $42,000	$54,001 - $60,000	Refuse

CONSENT FOR SERVICE

I give permission for my child, named above, to receive SBHC services while he/she is enrolled in school and for SBHC staff to access my child's class schedule (for appointment purposes only). I understand that SBHC services are confidential, except in a life-threatening situation or when emergency services are needed and in accordance with the law. I give permission to the SBHC to exchange pertinent information to appropriate persons for the purpose of providing healthcare, diagnosis, treatment and counseling services, as well as for maintaining quality and safety. I understand that SBHC health records are confidential and will not be shared unless written consent is provided by the student and/or parent/guardian. I have received a copy of the HIPAA Notice of Privacy Practices. I understand the New Mexico law does not require parental consent for treatment or advice about sexually transmitted diseases, pregnancy or contraception to minors under 18 years of age and behavioral health counseling services to minors age 14 years or older. I am consenting to the following services to be provided to my child at the SBHC:

☐ **Medical** ☐ **Behavioral Heatlh** ☐ **Dental** ☐ **Dental Emergency Only**

Signature of Parent/Guardian	Date
Signature of patient, if 18 years or older	Date