DE BACA FAMILY PRACTICE CLINIC

	SCHOOL BASED HEALTH	CENTER P	PATIENT	REGIS	TRATION ANI	O CONSENT		SY 2019-20)
7	Patient Name (last, first, middle)		Mailing Address (city, state, zip)				Social Security	No.	
Ó									
Ė						Date of Birth			
Š	Parent(s)/Legal Guardian(s) Name(s)		Parent/Guardian Cell				1		
쬬							Grade		
6			Parent/Guardian Work Number				- Grade		
Z			Parent/Guardian work number				Hama Bhana		
5							Home Phone		
Ш			Emergency Contact Phone Number Patient Race (circle all that apply) White						
9							Sex Male Female		
STUDENT INFORMATION							African American Asian Hawaiian Other Pacific Islander		
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	Primary Care Physican			Primary Dental Provider					
F				0					
MEDICAL INFO	Phone Number		Phone Number Name of Dental Insurance Policy Number						
7	Name of Medical Health Insurance			Name of Dental Insurance					
<u>⊘</u>									
⊡	Policy Number		Policy Number						
Ξ		🖁							
	Relationship to Patient		Relationship to Patient			Patient			
	Current Medication & Dosa	List ALL Allergies				Surgeries/Hospitalizations			
≖ ≿	(including over the counter)			(including food/enviromental)					
HEALTH HISTORY									
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出業									
	□ None □ None							None	
					☐ None			□ MOHE	
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	Sexual Orientation: (please circle) Straight (Not Lesbian/Gay)	Gen		<u>ity:</u> (pleas 1ale		_			your
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