TIGER [DEN WELI	LNESS	CENTER
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PATIENT REGISTRATION AND CONSENT FOR SERVICES		SCHOOL BASED HEALTH CENTER				
	Patient Name (last, first, middle)		Date of Birth Social Security Number			Grade
				Student ID Number		
Z						
Ц	Patient Address (street, city, state, and zip) Parent(s)/Legal Guardian(s) Name(s) Parent(s)/Legal Guardian(s) Address (street, city, state and zip) Emergency Contact Person Name and Relationship to Patient		Patient Phone - home			
-A			Patient Phone - Cell			
N N	Parent(s)/Legal Guardian(s) Name(s)		Patient Sex 🛛 Male	□ Female		
0			Patient Race Black	🗆 White 🗖 Nati	ve American/Alaska Native	
Ž			□ Hispanic □ Other			
Ę	Parent(s)/Legal Guardian(s) Add	ress (street, city, state and zip)	Home Phone			
Ш			Work Phone			
			Cell Phone			
)T	Emergency Contact Person Name and Relationship to Patient		Emergency Phone - Home			
•,			Emergency Phone - Cell			
			Emergency Phone Work			
	Primary Care Physician		Primary Care Physician Phone N	umber		
N						
Ĭ	Primary Care Physician Address					
W		· • • • • • • • • • • • • • • • • • • •				
0K	Name of Health Insurance (If no	insurance coverage, please enter N/A)	Medicaid coverage Blue Cross/Blue Shield Cent	□ No	United CC	
L Z			Blue Closs/Blue Silleid Cell			
- H			Molina CC Pres Medicaid Number:	shyterian CC	Eee-Eor-Service	
Ň	Policy Number					
JR/						
เรา	Name of Policy Holder	Primary Care Physician Address Name of Health Insurance (If no insurance coverage, please enter N/A) Policy Number Name of Policy Holder Name of Policy Holder				
Z						
Z					List Currer	nt
N	List any allergies	List any surgeries When/Where	List Hospitalizations	When/Where	List Currer Medications/ Do	
N	List any allergies	List any surgeries When/Where	List Hospitalizations	When/Where		
	List any allergies	List any surgeries When/Where	List Hospitalizations	When/Where		
	List any allergies	List any surgeries When/Where	List Hospitalizations	When/Where		
	List any allergies	List any surgeries When/Where	List Hospitalizations	When/Where		
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	List any allergies	List any surgeries When/Where	List Hospitalizations	When/Where		
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НЕАLTH НІЗТОRY	List any allergies	List any surgeries When/Where	List Hospitalizations	When/Where		
				When/Where		
		List any surgeries When/Where		When/Where		
				When/Where		
	List any family health conditions	which may be inherited (i.e. high blood pressure, ho	aart disease):		Medications/ Do	bsages
	List any family health conditions		SBHC services while I	ne/she is enro	Medications/ Do	d for
НЕАLTH HISTORY	List any family health conditions I give permission for r SBHC staff to access confidential, except in	which may be inherited (i.e. high blood pressure, ho my child, named above, to receive my child's class schedule (for app a life-threatening situation or whe	SBHC services while I pointment purposes on en emergency services	ne/she is enro ly). I understal are needed a	Iled in this school an nd that SBHC servic nd in accordance wit	d for es are th the law.
НЕАLTH HISTORY	List any family health conditions BHC staff to access confidential, except in give permission to th	my child, named above, to receive my child's class schedule (for app a life-threatening situation or when the SBHC to exchange pertinent int	SBHC services while I pointment purposes on en emergency services formation to appropriat	ne/she is enro ly). I understar are needed a e persons for	Iled in this school an nd that SBHC servic nd in accordance wit the purpose of provi	d for es are th the law. ding
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