



Student Information		
Student Last Name (legal):		Student Number:
First Name (legal):	Student Middle Name (full):	
Home Address:	City:	Zip:
Gender: M / F	Birth Date (mm/dd/yyyy): / /	
Grade:	Name of School Attending:	
Parent/Guardian		
Parent Last Name (legal):		Parent First Name (legal):
Parent Middle Name (full):		Parent Birthdate (mm/dd/yyyy):
Parent/Legal Guardian: <input type="checkbox"/> Yes <input type="checkbox"/> No		Relationship to Student:
Home Phone:	Work Phone:	Cell Phone:
Email:	May we text your cell phone number? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Second Parent/Guardian		
Parent Last Name (legal):		Parent First Name (legal):
Parent Middle Name (full):		Parent Birthdate (mm/dd/yyyy):
Parent/Legal Guardian: <input type="checkbox"/> Yes <input type="checkbox"/> No		Relationship to Student:
Home Phone:	Work Phone:	Cell Phone:
Email:	May we text your cell phone number? <input type="checkbox"/> Yes <input type="checkbox"/> No	
School Based Health Services		
<p>School-based health services (SBHS) will be available at your child's school or a nearby school. These services will be provided by OneWorld Community Health Centers (OWCHC), Charles Drew Health Center (CDHC), UNMC, Creighton University (Creighton), Children's Hospital & Medical Center (Children's) or other contracted service providers. The school nurse will coordinate care with the school-based health service providers once your child is enrolled.</p> <p>SBHS will coordinate care with your child's primary care provider, dentist, optometrist/ophthalmologist and/or behavioral health provider. If you have private health insurance or Medicaid, SBHS providers will bill your insurance carrier for services provided. If you do not have health insurance, the SBHS provider will assist families with enrollment in Medicaid, if eligible.</p>		
School Based Health Centers		
<p>School Based Health Centers (SBHC): ability to screen health status, test for, diagnose and treat common conditions, e.g., sore throats, minor injuries, headaches, immunizations, ear infections, and diseases such as hepatitis, tuberculosis and sexually transmitted diseases. Nebraska state law allows students to choose whether a parent will be notified of a student's care related to sexually transmitted infections. The SBHC will not provide emergency services. The SBHC may provide behavioral and/or psychiatric services and may also include the use of telehealth technology.</p> <p>To enroll your child in SBHC and allow OPS to give SBHC staff confidential information for diagnosis and treatment, a signed enrollment and consent form must be on file with OPS and the SBHC provider. The SBHC staff will attempt to contact you regarding your child's visit and services provided.</p> <p>By signing this enrollment and consent form, you consent to the following:</p> <ul style="list-style-type: none"> I authorize OneWorld Community Health Center and Charles Drew Health Center to examine and treat my child with school-based health services, and I understand that no guarantee has been made as to the results of such examinations and treatments. I authorize OPS staff, including the school nurse, and United Way of the Midlands on behalf of OPS, to release the following student information to the School Based Health Centers identified above so that they can provide services and conduct program evaluation: family and emergency contact information, state student number, attendance and disciplinary records, schedule, immunization history, results of health screenings such as hearing and vision, psychological evaluations, special education (IEP-MDT) records, Section 504 Accommodation Plan, and information regarding any health condition, such as seizures, allergies, concussions or asthma. 		
Dental Services		
<p>Dental Services: Where required by law, OPS provides dental screening services conducted by parties contracting with OPS. Services may include oral health education, screenings, fluoride varnish application, preventative care/cleaning, restorative/corrective care, and use of telehealth technology. OPS may provide dental screenings in addition to those required by law. By signing this consent form, you consent to the following:</p> <ul style="list-style-type: none"> I authorize UNMC, OWCHC, CDHC, Creighton and/or other contracted provider to examine and treat my child with dental screenings and follow-up treatment, and I understand that no guarantee has been made as to the results of such examinations and treatments. I authorize OPS staff, including the school nurse, to release the following student information to the identified dental service providers so they can provide services and conduct program evaluation: family contact information, state student number, schedule, and results of dental screenings. 		
Vision Services		
<p>Vision Services: Where required by law, OPS provides vision screening services conducted by parties contracting with OPS. OPS may provide vision screening services in addition to those required by law. Services may include screening, examination, treatment and/or corrections such as eyeglasses, and may include telehealth. By signing this consent form, you consent to the following:</p> <ul style="list-style-type: none"> I authorize Children's and/or other contracted provider to examine and treat my child with vision screenings (where OPS is not required by law to provide the screenings) and exams, and I understand that no guarantee has been made as to the results of such examinations and treatments. I authorize OPS including the school nurse, to release the following student information to the identified vision service providers so they can provide services and conduct program evaluation: family contact information, state student number, schedule, and results of vision screenings and exams. 		
<p>This authorization expires when my child leaves OPS or graduates. I understand that I may revoke this authorization at any time by submitting a letter to the Omaha Public Schools, Student Information Services, 3215 Cuming Street, Omaha, NE 68131-2024 or by checking the box to revoke below.</p>		
School Based Health Centers	<input type="checkbox"/> No <input type="checkbox"/> Yes	I authorize OneWorld Community Health Center and Charles Drew Health Center to examine and treat my child as described above. I further authorize OPS to release information as described above.
Dental Services	<input type="checkbox"/> No <input type="checkbox"/> Yes	I authorize my child to receive dental services through UNMC, OWCHC, CDHC and/or Creighton. I further authorize OPS to release information as described above.
Vision Services	<input type="checkbox"/> No <input type="checkbox"/> Yes	I authorize my child to receive vision services through Children's and/or other contracted service providers as described above. I further authorize OPS to release information as described above.
_____ Parent/Guardian Signature		_____ Relationship to Child
		_____ Date

Omaha Public Schools does not discriminate on the basis of race, color, national origin, religion, sex (including pregnancy), marital status, sexual orientation, disability, age, genetic information, gender identity, gender expression, citizenship status, veteran status, political affiliation or economic status in its programs, activities and employment and provides equal access to the Boy Scouts and other designated youth groups. The following individual has been designated to accept allegations regarding non-discrimination policies: Superintendent of Schools, 3215 Cuming Street, Omaha, NE 68131 (531-299-9822). The following individual has been designated to handle inquiries regarding the non-discrimination policies: Director for the Office of Equity and Diversity, 3215 Cuming St, Omaha, NE 68131 (531-299-9765).

Información del Estudiante			
Apellido del Estudiante (legal):		Número de Estudiante:	
Primer Nombre del Estudiante (legal):		Segundo Nombre del Estudiante (completo):	
Dirección de la casa:		Ciudad:	Código Postal:
Sexo:		Fecha de Nacimiento (mes/día/año):	
Grado:		Nombre de la Escuela que Asiste:	
Padre/Madre/Tutor			
Apellido del Padre/Madre/Tutor (legal):		Primer Nombre (legal):	
Segundo Nombre (completo):		Fecha de Nacimiento (mes/día/año):	
Padre/Madre/Tutor Legal: <input type="checkbox"/> Sí <input type="checkbox"/> No		Relación con el Estudiante:	
Teléfono de Casa:		Teléfono del Trabajo:	Teléfono Celular:
Correo electrónico:		¿Podemos enviarle mensajes de texto a su número? <input type="checkbox"/> Sí <input type="checkbox"/> No	
Padre/Madre/Tutor			
Apellido del Padre/Madre/Tutor (legal):		Primer Nombre (legal):	
Segundo Nombre (completo):		Fecha de Nacimiento (mes/día/año):	
Padre/Madre/Tutor Legal: <input type="checkbox"/> Sí <input type="checkbox"/> No		Relación con el Estudiante:	
Teléfono de Casa:		Teléfono del Trabajo:	Teléfono Celular:
Correo electrónico:		¿Podemos enviarle mensajes de texto a su número? <input type="checkbox"/> Sí <input type="checkbox"/> No	
Servicios de Salud basados en la Escuela			
<p>Los servicios de salud basados en la escuela (siglas en inglés SBHS) estarán disponibles en la escuela de su hijo o en una escuela cercana. Estos servicios serán provistos por los Centros de Salud Comunitarios OneWorld (siglas en inglés OWCHC), el Centro de Salud Charles Drew (siglas en inglés CDHC), UNMC, Universidad Creighton (Creighton), Hospital de Niños & Centro Médico (Children's) u otros proveedores de servicios contratados. La enfermera de la escuela coordinara el cuidado con los proveedores de servicio de salud ya que su hijo sea inscrito.</p> <p>SBHS coordinara el cuidado con el proveedor principal del cuidado de su hijo, dentista, optometrista/oftalmólogo y/o proveedor de salud de conducta. Si usted tiene un seguro de médico privado o Medicaid, los proveedores de SBHS enviarán la factura a su seguro por los servicios provistos. Si usted no tiene seguro médico, SBHS ayudara a las familias con la inscripción a Medicaid, si es elegible.</p>			
Centros de Salud basados en la Escuela			
<p>Centros de Salud basados en la Escuela (siglas en inglés SBHC): tienen la habilidad de evaluar el estado de salud, examinar, diagnosticar y tratar condiciones comunes, ej. Dolores de garganta, lesiones menores, dolores de cabeza, vacunas, infecciones de oídos, y enfermedades tales como el hepatitis, tuberculosis y enfermedades transmitidas sexualmente. La ley del estado de Nebraska permite a los estudiantes a escoger ya sea que un padre sea notificado del cuidado relacionado a infecciones transmitidas sexualmente. El SBHC no proveerá servicios de emergencia. El SBHC podrá proveer servicios de conducta y psiquiátricos y puede también incluir el uso de tecnología de tele salud.</p> <p>Para inscribir a su hijo en SBHC y permitir a OPS a proveer información confidencial al personal de SBHC para el diagnóstico y tratamiento debemos tener en nuestros expedientes de OPS y del proveedor SBHC un formulario de inscripción y consentimiento firmado. El personal de SBHC tratara de contactarlo a usted referente a la visita y los servicios provistos a su estudiante. Al firmar este formulario de inscripción y consentimiento, usted da el consentimiento a lo siguiente:</p> <ul style="list-style-type: none"> Yo autorizo al Centro de Salud Comunitario OneWorld y/o al Centro de Salud Charles Drew, para examinar y tratar a mi hijo con los servicios de salud basados en la escuela y entiendo que no se ha hecho ninguna garantía de los resultados de tales exámenes y tratamientos. Yo autorizo al personal de OPS, incluyendo a la enfermera escolar, el "United Way of the Midlands" de parte de OPS, a liberar la siguiente información del estudiante al SBHC identificados anteriormente para que provean servicios y lleven a cabo una evaluación del programa: Información de contactos de familia y de emergencia, número del estado del estudiante, asistencia y récords de disciplina, horarios, historial de vacunas, resultados de evaluaciones de salud tales como de audición y visión, evaluaciones psicológicas, récords de educación especial (IEP-MDT), Sección 504 del Plan de Adaptación, e información concerniente a la condición de salud tal como convulsiones, alergias, conmoción cerebral y asma. 			
Servicios Dentales			
<p>Servicios Dentales: Donde sea requerido por la ley, OPS provee servicios de evaluación dentales conducidos por contratistas por OPS. Los servicios pueden incluir educación de salud oral, evaluaciones, aplicación de barniz de fluoruro, limpieza/cuidado preventivo, cuidado restaurativo/correctivo, y uso de tecnología de tele salud. OPS puede proveer evaluación dental junto con lo requerido por la ley. Al firmar este formulario de inscripción y consentimiento, usted da consentimiento a lo siguiente:</p> <ul style="list-style-type: none"> Yo autorizo a UNMC, OWCHC, CDHC, Creighton, y/u otros proveedores contratistas para evaluar y tratar a mi hijo con exámenes dentales y evaluaciones de tratamiento de continuación y entiendo que no se ha hecho ninguna garantía de los resultados de tal examinación y tratamiento. Yo autorizo al personal de OPS, incluyendo la enfermera escolar, para liberar la siguiente información estudiantil a los proveedores de servicio dentales identificados y para conducir la evaluación del programa, número de estudiante estatal y resultados de evaluaciones dentales. 			
Servicio de Visión			
<p>Servicios de Visión: Donde sea requerido por la ley, OPS provee servicios de evaluación de la visión conducidos por partes contratados con OPS. OPS puede proveer servicios de evaluación de visión adjunto a aquellos requeridos por la ley. Los servicios pueden incluir evaluaciones, exámenes, tratamientos y/o correcciones tales como lentes y puede incluir tele salud. Al firmar este formulario, usted da el consentimiento a lo siguiente:</p> <ul style="list-style-type: none"> Yo autorizo a Children's y/u otros proveedores contratados para examinar y tratar mi hijo con evaluaciones de visión (donde OPS no está requerido por ley a proveer las evaluaciones) y exámenes, y entiendo que no se ha hecho ninguna garantía de los resultados de tal examinación y tratamientos. Yo autorizo al personal de OPS, incluyendo la enfermera escolar, para liberar la siguiente información estudiantil a los proveedores de servicios de visión identificados y para conducir la evaluación del programa, información de contacto de la familia, número de estudiante estatal y resultados de evaluaciones y tratamientos de visión. <p>Esta autorización expira cuando el niño dejé OPS o se gradué. Yo entiendo que puedo revocar esta autorización en cualquier momento al entregar una carta para la Escuela Pública de Omaha, Servicios de Información Estudiantil, 3215 Cuming Street, Omaha, NE 68131-2024 o al marcar la casilla para revocar abajo.</p>			
<p>Centro de Salud Basado en la Escuela <input type="checkbox"/> No <input type="checkbox"/> Sí</p>	Yo autorizo a Centro Comunitario OneWorld y Charles Drew a examinar y tratar a mi hijo como se describe arriba. Yo autorizo a OPS a liberar la información como se describe arriba.		
<p>Servicios Dental <input type="checkbox"/> No <input type="checkbox"/> Sí</p>	Yo autorizo a mi hijo a recibir servicios dentales a través de UNMC, OWCHC, CDHC y/o Creighton. Yo autorizo a OPS a liberar la información como se describe arriba.		
<p>Servicios de Visión <input type="checkbox"/> No <input type="checkbox"/> Sí</p>	Yo autorizo a mi hijo a recibir servicios de visión a través de Children's y/u otros proveedores de servicios contratados como se menciona arriba. Yo autorizo a OPS a liberar la información como se describe arriba.		
<p>_____ Firma del padre/tutor</p>	<p>_____ Relación con los hijos</p>	<p>_____ Fecha</p>	

Las Escuelas Públicas de Omaha no discriminan fundamentado en la raza, color, origen nacional, religión, sexo (incluyendo embarazo), estado civil, orientación sexual, discapacidad, edad, información genética, identidad de género, expresión de género, estatus migratorio, estatus de veterano, afiliación política o estatus económico en sus programas, actividades y empleo, y proporciona acceso equitativo a los "Boy Scouts" y a otros grupos juveniles designados. Las siguientes personas ha sido designadas para aceptar cualquier queja en relación a las políticas de no discriminación: El Superintendente de las Escuelas, 3215 Cuming Street, Omaha, NE, 68131 (531-299-9823). La siguiente persona ha sido asignado para manejar quejas referentes a las políticas de no discriminación: El Director para la Oficina de Equidad y Diversidad, 3215 Cuming St, Omaha, NE 68131 (531-299-0307).

Para el Uso De La Oficina Solamente Verified Programs Sections Initials

CONSENT TO TREAT

Authorization for Health Care

Patient's name: _____

Please read and review each section and sign where prompted.

- 1. Authorization for Medical Treatment.** I do hereby acknowledge, agree, and give my consent for diagnosis, treatment, behavioral health treatment, dental treatment, as deemed necessary by Charles Drew Health Center, Inc. as indicated appropriate by my treating provider, their assistants and/or designees. This Authorization includes, but is not limited to, routine diagnostic procedures, outpatient and inpatient care, laboratory test, x-rays and other tests or procedures. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician(s) or provider whose care I am under. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as result to examination and treatment received at this Facility. I acknowledge that my care is under the direction of my treating provider and the Charles Drew Health Center, Inc. facility will follow the instructions of my provider(s) in the position in said care.
- 2. Patient Care.** I, the undersigned, agree to uphold my responsibilities to take charge of my health care, working with my provider and maintaining compliance with my providers designated care plan for my health and well being.
- 3. Personal Valuables.** I accept full responsibility for all property in my possession. I understand that Charles Drew Health Center, Inc. maintains no responsibility for property that is personal and in my possession.
- 4. Duration and Scope.** I understand this agreement will be valid for one year (12 months) from the date it is signed, unless I cancel it sooner. This agreement will apply to any care provided to the patient at any Charles Drew Health Center Inc. locations during the next year, unless the care provided requires additional consents by law.
- 5. Physician and Staff Employment.** Some providers at Charles Drew Health Center Inc. may be independent contractors who use Charles Drew Health Center Inc. facilities to provide care to their patients ("Contractors"). As such, these various independent contractors may submit bills for the professional services they provide separate from the bill Charles Drew Health Center Inc. may submit. Contractors are responsible for their own actions and Charles Drew Health Center Inc. is not liable for their actions or failure to act.
- 6. Assignment of Facility Benefits.** I hereby assign all insurance benefits and/or Medicare/ Medicaid benefits to Charles Drew Health Inc. and authorize direct payment to facility. This payment includes all payments for charges incurred during treatment, visit and observation at all clinics for Charles Drew Health Inc. I agree that I am responsible for the financial aspect of my healthcare and will maintain compliance for any and all insurance plans, Medicare/Medicaid and any self-pay and/or sliding fee details. A photocopy of this agreement shall be as valid as the original.
- 7. Assignment of Professional Benefits.** I hereby assign all insurance benefits and/or Medicare/ Medicaid benefits to all physician(s), therapist(s), and/or medical professionals providing services to me and authorize direct payment to physician(s) and therapist(s). I agree to pay for any and all charges not paid pursuant to this assignment. A photocopy of this assignment shall be as valid as the original.
- 8. Authorized Representative.** I hereby authorize Charles Drew Health Center Inc. and its facilities, its agents and representatives to act on my behalf to recover benefit claims, appeal adverse benefit determinations, and to take any action deemed necessary to obtain payment for services provided to me by said Facility(s).
- 9. Statement of Responsibility.** I understand that I am financially responsible to Charles Drew Health Center Inc. as the patient, guardian, and conservator or insured for all charges not covered by the above assignments or programs. Charges may include medical insurance deductibles, co-insurance out-of-pocket expenses.
- 10. Sliding Fee Discount Program Policy.** Charles Drew Health Center Inc. has a sliding fee discount program and I may ask about it at any time. There is an application process for sliding fee, and eligibility is based on family size, family income, and other special circumstances. I may request a sliding fee application at any time.
- 11. Self-Payment.** I understand I may choose to not have Charles Drew Health Center Inc. bill my and/or the patient's insurance for a particular health care item or service provided to the patient, and instead choose to personally pay in full the cost of that health care item or service. To exercise this option, I must notify Charles Drew Health Center Inc. in a timely manner, complete additional forms, and pay all applicable charges promptly and in full.

12. Authorization to Release Information to Insurance Company/Third Party Payer. I hereby authorize Facility(s), any authorized healthcare provider, including Veterans Administration or governmental hospital, any insurance company or other person, institution, or organization to release my medical records to any person, corporation, workers compensation carrier, governmental agency (or representative thereof) which is or may be, liable under any contract or governmental program to this Facility, the patient, or a family member for all or part of the Facility(s) charge. This Facility will endeavor to protect the confidentiality of my medical records. However, the Facility shall not be liable by reason of its release of said medical records or any part thereof when responding in good faith to an apparently valid release. I authorize release of pertinent records to pharmaceutical companies as needed.

13. Non-covered Medicare/Medicaid Services. The Medicare and Medicaid Programs have certain charges that are excluded from coverage, including but not limited to: cosmetic surgery, non-medically related dental surgery, routine diagnostic workups, routine physical exams, and oral drugs. I acknowledge I am financially responsible for all charges incurred if my medical/dental chart indicates for any of the listed treatments or care as listed.

14. Shadowing and Observation. Some people involved in patient's care may be medical, nursing, or other health care personnel in training. I consent to their participation. Other non-Charles Drew Health Center Inc. staff members may observe the patient's care. I have the right to request that any of these individuals not participate in or observe the patient's care and this request will not affect the patient's care at Charles Drew Health Center Inc.

15. Contact by Phone. By providing Charles Drew Health Center Inc. with my land line and/or cell phone number(s), I give my express consent for Charles Drew Health Center Inc., its contractors, agents, and collection agents to contact me at these numbers, or at any number that I later acquire, and to leave live or pre-recorded messages or to send text messages regarding accounts or services. I understand that for greater efficiency, calls may be delivered by an auto-dialer.

16. Advanced Instructions for Healthcare. I understand that I may indicate in writing (Advanced Directions, i.e. Living Will and Durable Power of Attorney) my desire to receive, select, and/or define medical or surgical treatment or choose non-treatment Charles Drew Health Center Inc. will recognize such instructions in accordance with Nebraska and/or Iowa State law and the Facility(s) policies if either both Advance Direction statement(s) are provided to the Facility(s) so that a copy is filed with any medical record.

_____ Please Initial. I acknowledge notification of Charles Drew Health Center, Inc. Patient Rights and Responsibilities.

_____ Please Initial. I acknowledge notification of Charles Drew Health Center, Inc. Privacy Practices.

HIV Consent. I hereby authorize Charles Drew Health Center to test my blood and the Counseling, Testing and Referral/Partner Counseling and Referral Services (CTR/PCRS) of the Nebraska Department of Health & Human Services Infectious Disease Section, HIV/AIDS Prevention (DHHS) to provide the confidential and anonymous laboratory analysis for the HIV antibody.

I wish to be tested confidentially

I wish to be tested anonymously

I wish to **refuse HIV testing**

The undersigned certifies that he or she has read the foregoing, and all questions have been answered. The signee is the patient, patient's guardian, power of attorney, parent, or is duly authorized by or on behalf of the patient to execute the above and accept its terms.

Patient/Parent/Power of Attorney/Guardian Signature: _____ Date: _____

Responsible Party's Signature (if not the same as patient/parent): _____

Insured's Signature: _____ Witness to Signature: _____

Patient unable to sign consent because: _____



SBHC RELEASE OF INFORMATION

Please read the following statements and fill out information where prompted

Child name: _____ Birth date: _____

Parent/Guardian name: _____ Phone: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

As the parent or legal guardian of a child enrolled in the school based health center, I understand that the sharing of information related to my child's care with certain school staff, and the child's Primary Care Physician (PCP) may support care coordination for my child. The purpose of the disclosure is to allow Charles Drew Health Center ("Charles Drew") to provide OPS certificated staff, school contacts, and my PCP with information about my child's health status, medications, treatments, and clinic visits which is important for my child's safety and to promote the health and educational success of my child.

I give permission for Charles Drew staff to furnish records and discuss details regarding my child's care and treatment to my Primary Care Physician (PCP). The child's PCP is _____

Please choose one: Yes No Does not apply

I hereby authorize any staff of Charles Drew to furnish records and to discuss details of child's care and treatment at the school-based health center with certificated staff (school nurses, counselors, teachers, therapists, administrators) at Omaha Public Schools (OPS). By marking "yes," I give permission for Charles Drew staff to exchange information with school personnel and/or Methodist Community Counseling or CHI counseling staff (if applicable) about my child and/or my child's treatment or medical care for the duration of my child's care.

Please choose one: Yes No Does not apply

By signing, below, I understand and acknowledge that:

1. Charles Drew will not refuse to services to my child if I refuse to sign this Authorization.
2. Medical information that is disclosed because of this Authorization may be subject to re-disclosure by the recipient and no longer protected by State Law.
3. The authorization remains effective while my child is enrolled in the Omaha Public Schools. This authorization automatically expires when my child is no longer enrolled in the Omaha Public Schools.
4. I understand that I may revoke this Authorization at any time by giving written notice to the medical professional or medical assistant on duty at the school-based health center where my child receives services.
5. I understand that my revocation is not effective as to disclosures already made and actions already taken based upon this Authorization.
6. I have received a copy of this document.

Dates of Service From: _____ To: _____

Information to be disclosed

- | | | |
|---|------------------------------------|---|
| <input type="checkbox"/> Abstract: Notes and/or Labs | <input type="checkbox"/> H/P | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> The entire health record including alcohol and substance testing or treatment, HIV/AIDS status or related information and Reproductive Health. | <input type="checkbox"/> Labs ONLY | <input type="checkbox"/> Complete medical records, including progress notes, visit notes, labs and X-ray reports. |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Radiology | |

Specific authorization for Release of Information protected by State or Federal Law

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Mental health testing, counseling and treatment information | <input type="checkbox"/> STD/HIV |
| <input type="checkbox"/> Chemical dependency (drug and alcohol) | <input type="checkbox"/> Other: _____ |

For purpose of: Continuity of care Personal reasons Legal reasons Moving Transfer of care Other

Signature of patient or legal guardian: _____ Date: _____

Relation to patient (if not self): _____

EXPIRATION: This authorization is effective for 12 months but no longer than one year from the date on which it was signed.

Note: A parent or legal guardian must sign if patient is a minor (NE – under age 19, IA – under age 18) except for reproductive health and HIV testing. If signed by a patient's authorized representative, supporting legal documentation must accompany this form.
Notice to Recipient: The federal rule prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted (42CFR Part 2). A general authorization for release of protected health information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

PATIENT REGISTRATION FORM

All information requested within this form is essential to ensure quality patient care or required by federal law. It will be kept private and confidential as a part of the patient's medical record.

SECTION I: PATIENT INFORMATION AND DEMOGRAPHICS

First Name: _____ Last Name: _____

Preferred Name: _____ Middle Initial: _____

Social Security Number (SSN): _____ Date of Birth (mm/dd/yyyy): _____

Optional

School Attending: _____

If applicable

Address: _____ City: _____ State: _____ Zip: _____

Please fill out any/all contact methods. Check box for preferred contact method:

Cell Phone: _____ May we leave a voicemail? Yes No

May we text this number? Yes No

Home Phone: _____ May we leave a voicemail? Yes No

Alt. Phone: _____ May we leave a voicemail? Yes No

Email Address: _____

Emergency Contact: _____

Relationship to Patient: _____ Phone Number: _____

Preferred Language: _____ Interpreter Needed?: Yes No

How did you hear about Charles Drew Health Center, Inc.? _____

Please check which of the following best describes your sex assigned at birth:

Male Female

Please check which of the following best describes your gender identity:

Male Female Transgender male/
female-to-male Transgender female/
male-to-female
 Choose not to disclose Don't know/Not applicable

PATIENT REGISTRATION FORM

Please check which of the following best describes your sexual orientation:

- Straight/heterosexual
 Lesbian, gay or homosexual
 Something else
 Bisexual
 Choose not to disclose
 Don't know/Not applicable

Please check which of the following best describes your preferred pronouns:

- He, Him, His
 She, Her, Hers
 They, Them, Theirs
 Ze, Hir
 Decline to answer
 Unknown
 Other: _____

Please provide information on your medical provider:

Primary Medical Provider: _____ None/Unknown

Address: _____ City: _____ State: _____ Zip: _____

Please provide information on your dental provider:

Primary Dental Provider: _____ None/Unknown

Address: _____ City: _____ State: _____ Zip: _____

Please check which of the following best describes your current housing. Please only select one:

- Homeless shelter
 Transitional housing
 Doubling up
 Street
 Section 8
 Public housing
 Rent/Own

Please answer the following questions:

- Are you a veteran? Yes No
 Are you a migrant farm worker? Yes No Seasonal

Please check which of the following best describes your race. Please only select one:

- American Indian or Native Alaskan
 Asian
 Black or African American
 Native Hawaiian
 Pacific Islander
 White
 More than one race
 Unknown, not listed, or refuse to report

Please check which of the following best describes your ethnicity. Please only select one:

- Hispanic, Latino, or Chicano
 Non-Hispanic, Latino, or Chicano
 Refuse to report

Please check which of the following best describes your primary medical coverage type. Please select only one:

- Medicaid
 Medicare
 Private or commercial insurance (including through Marketplace)
 None or uninsured



PATIENT REGISTRATION FORM

SECTION II: PATIENT HOUSEHOLD INFORMATION

Please **CIRCLE** your family size and household income range (should be in the same row).

Family Size:	Annual Income Ranges:					
1	\$0 - 12,760	\$12,761 - 15,950	\$15,951 - 19,140	\$19,141 - 22,330	\$22,331 - 25,550	Over \$25,550
2	\$0 - 17,240	\$17,241 - 21,550	\$21,551 - 25,860	\$25,861 - 30,170	\$30,171 - 34,480	Over \$34,480
3	\$0 - 21,720	\$21,721 - 27,150	\$27,151 - 32,580	\$32,581 - 38,010	\$38,011 - 43,440	Over \$ 43,440
4	\$0 - 26,220	\$26,221 - 32,750	\$32,751 - 39,300	\$39,301 - 45,850	\$45,851 - 52,400	Over \$52,400
5	\$0 - 30,680	\$30,681 - 38,350	\$38,351 - 46,020	\$46,021 - 53,690	\$53,691 - 61,360	Over \$61,360
6	\$0 - 35,150	\$35,151 - 43,950	\$43,951 - 52,740	\$52,741 - 61,530	\$61,531 - 70,320	Over \$70,320
7	\$0 - 39,640	\$39,641 - 48,550	\$48,551 - 59,460	\$59,461 - 69,370	\$69,371 - 79,280	Over \$79,280
8	\$0 - 44,120	\$44,121 - 55,150	\$55,151 - 66,180	\$66,181 - 77,210	\$77,212 - 88,240	Over \$88,240

SECTION III: RESPONSIBLE PARTY INFORMATION

Only complete this section if the responsible party is different from patient.

First Name: _____ Last Name: _____

Preferred Name: _____ Middle Initial: _____

Social Security Number (SSN): _____ Date of Birth (mm/dd/yyyy): _____

Optional

Address: _____ City: _____ State: _____ Zip: _____

Please fill out any/all contact methods. Check box for preferred contact method:

Home Phone: _____ May we leave a voicemail? Yes No

Cell Phone: _____ May we leave a voicemail? Yes No

May we text this number? Yes No

Alt. Phone: _____ May we leave a voicemail? Yes No

Email Address: _____

Preferred Language: _____ Interpreter Needed?: Yes No

SECTION IV: INSURANCE INFORMATION

Insurance Name: _____ Policy number/Enrollment ID: _____

Group ID: _____ Member ID: _____

I authorize release of information regarding continuation of care and/or any payments for services. I authorize a copy of this document may be used as the original document. I certify all information provided is true and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____



Charles Drew

HEALTH CENTER, INC.

"Growing a Healthy Community"

SBHC HEALTH HISTORY

Patient Name: _____ Date: _____

Patient Medical History

Does your child have allergies? Yes No

Medicines: _____

Foods: _____

Latex: _____

Other: _____

Is your child taking medicine? Yes No

If yes, which ones? _____

Were there any problems with the pregnancy or birth of your child? Yes No

If yes, what were they? _____

Any serious injuries or accidents? Yes No

If yes, what are they? _____

Have you taken your child to the hospital recently? Yes No

Where? _____

Date? _____

Has your child been to clinics or urgent care centers for any health problems recently? Yes No

Where? _____

Date? _____

Does your child have any serious illnesses or medical conditions (like asthma, diabetes, anemia or infections)? Yes No

If yes, what are they? _____

Has your child ever spent the night in the hospital? Yes No

Where? _____

For what? _____

Has your child ever had surgery? Yes No

Where? _____

For what? _____

Patient Immunization History

Any your child's immunizations current? Yes No

Has your child had the chicken pox? Yes No

When was your child's last flu vaccine? Date: _____

When was your child's last tetanus vaccine? Date: _____

Which of the following illnesses has your child had?

Asthma? Yes No

Allergies? Yes No

Eye problems? Yes No

Ear infections? Yes No

Hearing problems Yes No

Tuberculosis? (Active or LTBI) Yes No

Heart problems? Yes No

Chest pain or pressure? Yes No

Liver disease? (Hepatitis) Yes No

Gastrointestinal problems? (GERDS, MSPI) Yes No

Urine infections? Yes No

Seizures? Yes No

Fainting or almost passing out? Yes No

Head injury/concussion? Yes No

Immune problems? (HIV, AIDs, etc.) Yes No

Mononucleosis? Yes No

ETOH/Drug abuse Yes No

Sprains/strains/broken bones Yes No

Any special testing like xrays, MRIs Yes No

Mental health issues? Yes No

Other, please explain: _____

Family Information

Who currently lives at home? Mother Father Siblings
 Other: _____

Does someone else care for your child? Yes No
Example: Daycare/after school care

Does the mother work? Yes No

Does anyone in the house smoke? Yes No

Family Medical History

Birth defects? Yes No

Kidney problems? Yes No

Intellectual disability? Yes No

Gastrointestinal problems? (GERDS, MSPI) Yes No

SIDS? Yes No

Anemia? Yes No

Deafness? Yes No

Bleeding disorders? Yes No

Asthma? Yes No

Immune problems? (HIV, AIDS, etc.) Yes No

Allergies? Yes No

Epilepsy? Yes No

Tuberculosis? (Active or LTBI) Yes No

Cancer? Yes No

Sudden death for no reason or from a heart problem? Yes No

Mental health issues? Yes No

Heart disease? Yes No

ETOH/Drug abuse Yes No

High blood pressure? Yes No

Other, please explain: _____

High cholesterol? Yes No

Liver disease? (Hepatitis) Yes No

General Health Questions

Do you have concerns regarding your child's physical, mental, and/or emotional development? Yes No
If yes, what are they? _____

Do you have concerns regarding your child's school performance? Yes No
If yes, what are they? _____

Is your child involved in special education classes/services? Yes No
If yes, what are they? _____

Do you have concerns your child to be in good health? Yes No
If no, what are your additional concerns? _____

Primary Care Provider and Pharmacy Information

Primary Care Provider: _____
Address: _____

Preferred Pharmacy: _____
Address: _____

Any additional providers your child sees regularly?
Provider Name: _____
Address: _____
Provider Name: _____
Address: _____