ANNUAL PATIENT REGISTRATION FOR SBHC SERVICES

San Jon School Based Health Center SY 2020-2021

STUDENT INFORMATION

Patient Name (last, first, middle)	Date of Birth	Social Security Number Student ID Number	Grade
Patient Address (street, city, state, and zip)	Patient Phone - home Patient Phone - Cell		
Parent(s)/Legal Guardian(s) Name(s)	Patient Sex ☐ Male ☐ Female Patient Race ☐ Black ☐ White ☐ Native American/Alaska Native ☐ Hispanic ☐ Other		
Parent(s)/Legal Guardian(s) Address (street, city, state and zip)	Home Phone Work Phone Cell Phone		
Emergency Contact Person Name and Relationship to Patient	Emergency Phone - Home Emergency Phone - Cell Emergency Phone Work		

PRIMARY CARE INFORMATION

Primary Care Provider	Primary Care Provider Phone Number
Primary Care Provider Address	
Comprehensive Well Exam (physical, EPSDT, well child visit, annual check-up) in last 12 months? ___ yes ___ no ___ Not sure	****Annual comprehensive well exams are recommended by the American Academy of Pediatrics to ensure health concerns are identified and treated long before they become chronic. If you have a primary care provider, but have not had a well exam in the last 12 months please schedule one with your primary care provider.****
If you do not have a primary care provider, the SBHC is able to provide a well exam for you (your child). Would you like your child to have a well exam in the SBHC this school year? ___ Yes ___ No	

HEALTH HISTORY

List any allergies	List any health chronic health conditions	List hospitalizations or surgeries: When/Where	List current medications/ dosages

List any family health conditions which may be inherited (i.e. high blood pressure, heart disease, diabetes):

INSURANCE INFORMATION

Name of Health Insurance (If no insurance coverage, please enter N/A)	Medicaid Coverage ☐ Yes ☐ No ☐ Blue Cross/Blue Shield ☐ Presbyterian CC ☐ Western Sky CC
Policy Number	Medicaid Number
Name of Policy Holder	Relationship to Patient