Teen Health Center, Inc.

Providing free medical and mental health care to Galveston County youth since 1985

PATIENT INFORMATION

Patient's Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth _____ (MM/DD/YYYY) Sex: ____ Male ____ Female

School: _____ Grade:_____

Ethnicity: __Hispanic __ Black __ White __ American Indian __ Asian/Pacific Islander __ Other _____

Patient Address: _____

Street Address City State Zip Code

Telephone Home:_____ Work:_____ Cell: _____

Email address: _____

Who is the patient's regular doctor?

Name: _____ Telephone: _____

Address: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Relationship to Patient: _____

Telephone Home: _____ Work: _____ Cell: _____

INSURANCE INFORMATION

Do you have Medicaid?

__ No __ Yes: Medicaid ID # _____

Do you have other insurance?

__ No __ Yes: Name _____

Coverage Number: _____

PATIENT MEDICAL HISTORY

Do you have any allergies to medicine?

__ No __ Yes

If yes, please describe: _____

_____

_____

Please state the medications you take: _____

_____

_____

P.O. Box 925, Galveston, TX 77553 www.teenhealthcenter.org Fax: 409-765-5026

Do you have allergies, sensitivities, or reactions to any substances
such as food, mold, pollen, animal dander, dust or insects? No Yes
Do you have asthma? No Yes
Have you ever had a seizure? No Yes
Do you have diabetes? No Yes
Do you have any known heart condition? No Yes
Have you ever had to stay overnight in the hospital? No Yes
Have you ever had surgery? No Yes
Have you suffered from any trauma or severe injury? No Yes
Have you had any mental health issues? No Yes
Do you have any other health problems? No Yes

Please explain any "yes" responses: _____

_____

_____

FAMILY HEALTH AND SOCIAL HISTORY

Has any family member had heart disease before age 50? No Yes
Does any family member have Tuberculosis (TB)? No Yes
Have there been any mental health issues in the family? No Yes
Does any family member smoke tobacco in the home? No Yes

Please explain any "yes" responses: _____

_____

_____

AUTHORIZATION FOR SPECIFIC HEALTH CARE SERVICES

Please complete:

- **Yes** or **No** (Please Circle One) – I consent to receive routine physical examinations, weight/fitness program, TB skin test, immunizations, management of minor illnesses and injuries - including laboratory tests and medications, and general health education.

- **Yes** or **No** (Please Circle One) – I consent to receive counseling for the treatment of mental health and developmental conditions, which may include evaluation, diagnosis, and if necessary, referrals.

- **Yes** or **No** (Please Circle One) – I consent to receive medications for the treatment of mental health and developmental conditions, which may include evaluation, diagnosis, and if necessary, referrals.

- **Yes or No** (Please Circle One) – I consent to receive reproductive services including family planning, birth control, and condoms.

- **Yes** or **No** (Please Circle One) – I consent to receive counseling and testing for the HIV/AIDS virus.

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PERMISSION FOR SCHOOL-BASED HEALTH CENTER SERVICES

I have read and understand the services listed above. My signature indicates my desire to receive the services I circled above from the Teen Health Center, Inc. I understand that confidentiality between the patient and the health provider will be ensured in accordance with the law. Teen Health Center works collaboratively with teaching hospitals and Universities. There may be times when learners (e.g., medical students, residents, graduate students) participate in patient care. The same HIPAA policies apply to these learners and confidentiality will be maintained. In the event of an emergency situation, I realize it may be necessary for the Teen Health Center, Inc to release my health information to the school district (i.e., Texas City or Galveston Independent School District) where my clinic is housed. This sharing of information is needed to protect my health and safety. I also realize that the Teen Health Center may share information with the school nurse to ensure that my vaccines are up to date. Separate authorization is required for sharing additional health information. I understand this information will remain confidential in accordance with federal and state laws.

My signature also indicates that I am aware that my health information may be released as indicated above and that I have been given the opportunity to review the Notice of Privacy Practices.

X _____ _____

Signature of Patient Date

☐ Check box if you do not want to receive information via email or mail from the Teen Health Center, Inc.

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