



Healthy Kids Clinic Registration Form Staff

District: _____

School: _____

2022-2023 School Year

PATIENT INFORMATION

Please complete the following information:

Patient's Last Name:	First Name:	Middle Name:
Date of Birth:	Social Security #:	Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address:	PO Box:	City: State: Zip:
Home Phone:	Cell Phone:	Employer Phone:
Emergency Contact Name & Phone:		
Additional Emergency Contact Name & Phone:		
What pharmacy do you use?	City:	Phone:
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino	
Race: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native American or Alaskan Native <input type="checkbox"/> Native Hawaiiin Pacific Islander		
As a Federally Qualified Health Center, Healthy Kids Clinic is required to collect information to ensure we are providing the appropriate medical care and financial assistance, as needed.		
How many people live in your home?	What is your annual household income?	
Who is your primary care physician?	Phone:	Fax:
<input type="checkbox"/> Check this box if you would like your primary care physician to receive a copy of your visit notes, labs, etc.		

MEDICAL INSURANCE INFORMATION

Primary Insurance Company Name:	ID Number:
Group Number:	Address of Policy Holder (if different than patient):
Whose name is on the policy?	Policy Holder's Date of Birth: Relationship to Patient:
<input type="checkbox"/> Check this box if you do not have medical insurance. You may be contacted by our Patient Financial Services department.	

Past Medical History

- | | | |
|---|--|---|
| <input type="checkbox"/> No Past Medical History | <input type="checkbox"/> Allergies | <input type="checkbox"/> ADHD |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Autism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Cerebal Palsy |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Diabetes Type I | <input type="checkbox"/> Diabetes Type II |
| <input type="checkbox"/> Concussion or Head Trauma | <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hypothyroid |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Speech Disorder | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Developmental Learning Disorder/Delay | |
| <input type="checkbox"/> RSV | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> MRSA Skin Infection | | |
| <input type="checkbox"/> COVID-19 Date of Diagnosis _____ | | |

Past Surgical History (with date included)

- | |
|---|
| <input type="checkbox"/> No Past Surgical History |
| <input type="checkbox"/> Tonsillectomy: _____ |
| <input type="checkbox"/> Adenoidectomy: _____ |
| <input type="checkbox"/> Appendectomy: _____ |
| <input type="checkbox"/> Ear Tubes: _____ |
| <input type="checkbox"/> Incision and Drainage: _____ |
| <input type="checkbox"/> Other: _____ |
| _____ |
| _____ |
| _____ |

Family History (Please label below with : **M** for mother, **F** for father, **S** for sibling, and **G** for Grandparent.)

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> Anxiety___ | <input type="checkbox"/> Asthma___ | <input type="checkbox"/> Congenital Heart Defect___ | <input type="checkbox"/> Cardiomyopathy___ | <input type="checkbox"/> Depression___ |
| <input type="checkbox"/> Diabetes Type I___ | <input type="checkbox"/> Diabetes Type II___ | <input type="checkbox"/> Epilepsy/Seizures___ | <input type="checkbox"/> High Blood Pressure___ | <input type="checkbox"/> High Cholesterol___ |
| <input type="checkbox"/> Hypothyroidism___ | <input type="checkbox"/> Heart Murmur___ | <input type="checkbox"/> Pacemaker___ | <input type="checkbox"/> Sickle Cell Anemia___ | |
| <input type="checkbox"/> Unexpected or unexplained death before the age of 35 years?___ | <input type="checkbox"/> Unknown | | | |

Medications

Do you currently take any medications? ___Yes ___No

Please list any medications with current dose (how much and how often): _____

Allergies

Are you allergic to environmental factors (bees, latex, nuts, food, etc.) or medications? ___Yes ___No

Please list any allergies with type of reaction (rash, lips swelling, can't breathe, etc.):

Name of Allergen

Type of Reaction

Is there any additional information you would like us to know about you? _____

Medical Release of Information

As the patient you have the right to give access of your medical records to whomever you choose. Please list below anyone you would like to have access to your medical records.

Name

Relationship to Patient

Phone Number

Name	Relationship to Patient	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I give consent to Cumberland Family Medical Center, Inc. School Based Health Center (hereinafter CFMC SBHC) staff to render the needed treatment, perform the needed test, and document attendance, immunizations, and any other information, if applicable, that will assist the staff in providing care for the patient/myself. I understand that CFMC shall provide a copy of its Notice of Privacy and HIPAA Practices upon my request, which is also available at www.cumberlandfamilymedical.com. **I authorize CFMC to release any information required for payment of insurance claims and authorize my insurance, Medicare or Medicaid to be paid directly to the clinic. I understand I am responsible for any co-payments and/or deductibles incurred from my insurance plan.** If this cannot be done, I agree to make arrangements with the clinic. I authorize CFMC SBHC staff to release and receive medical information from the patient/my primary care providers and specialists. I give consent for this protected health information to be shared with school district staff who may need to provide care in an emergency situation. Furthermore, I give consent for CFMC SBHC staff, Board of Education staff, and the patient/my primary care provider, to communicate and share medical and psychological conditions on an as needed basis with the understanding that all information will be treated in a confidential manner.

SIGNATURE REQUIRED

Signature

Print Name

Date



Healthy Kids Clinic • PO Box 2399
Russell Springs, KY 42642
Toll Free: (844) 435-0900