PATIENT REGISTRATION AND CONSENT FOR SERVICES			XXXXXXX SCHOOL BASED HEALTH CENTER			
	Patient Name (last, first, middle)		Date of Sirth			FY Grade
STUDENT INFORMATION	. '			Children ID Number		
				Student ID Number		
	Patient Address (street, city, sta	te, and zip)	Patient Phone - home			
			Patient Phone - Cell			
	Parent(s)/Legal Guardian(s) Name(s)		Patient Sex	☐ Female		
			Patient Race   Black	:    White   Nativ	L ve American/Alaska Native	1
=				☐ Hispanic	□ Other	
Z	Parent(s)/Legal Guardian(s) Address (street, city, state and zip)  Emergency Contact Person Name and Relationship to Patient		Home Phone			
日日			Work Phone			
			Cell Phone			
S.			Emergency Phone - Home Emergency Phone - Cèll			
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OR SHAPE OF SHAPE	Primary Care Physician		Emergency Phone Work  Primary Care Physician Phone Number  : :			
z			Primary Care Physician Phone Number			
9	Primary Care Physician Address					
JA						
INSURANCE INFORMATION	Name of Health Insurance (If no insurance coverage, please enter N/A)		if Medicaid coverage			
Ä			☐ Blue Cross/Blue Shield Salud	☐ Lovelace Salu	d 🗆 Molina Salud 🗆	
Щ			Presbyterian	Salud  Fee-For-	Service	
N N	Policy Number		Medicaid Number:			
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ISI	Name of Policy Holder		Relationship to Patient			
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