HEALTHY KIDS CLINIC
A Part of Cumberland Family Medical Center, Inc.

Healthy Kids Clinic Registration Form
Staff

District: _____
School: _____
2023-2024 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: ☐ Male ☐ Female

Street Address: 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: ☐ English ☐ Spanish ☐ Other: Race:

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino ☐ Other (write in ethnicity):

As a Federally Qualified Health Center, Healthy Kids Clinic is required to collect the following 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:

☐ 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:

☐ Check this box if you do not have medical insurance. You may be contacted by our Patient Financial Services department.

Past Medical History

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

Past Surgical History (with date included)

☐ No Past Surgical History
☐ Tonsillectomy: _____
☐ Adenoidectomy: _____
☐ Appendectomy: _____
☐ Ear Tubes: _____
☐ Incision and Drainage: _____
☐ Other: _____

Family History
(Please label below with : **M** for Mother, **F** for Father, **S** for Sibling, and **G** for Grandparent.)

☐ Anxiety___
☐ Asthma___
☐ Congenital Heart Defect ___
☐ Cardiomyopathy___
☐ Depression___
☐ Diabetes Type I___
☐ Diabetes Type II___
☐ Epilepsy/Seizures___
☐ High Blood Pressure___
☐ High Cholesterol___
☐ Hypothyroidism___
☐ Heart Murmur___
☐ Pacemaker___
☐ Sickle Cell Anemia___
☐ Unexpected or unexplained death before the age of 35 years?___
☐ Unknown

OVER →

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

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***

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