FACULTY/STAFF ENROLLMENT FORM
SCHOOL YEAR: 2025-2026

In which HCSD facility do you work? ___Mulberry Creek ___New Mountain Hill ____Park ___Pine Ridge
____ Creekside ____ HCCMS ___ HCHS ____ STC ____EOC ____LEAP ____Central Office

PATIENT INFORMATION

Name _____ Date of Birth_____ Age_____

Social Security Number: _____ Sex: ____ M ____F Other_____

Home Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____Email Address: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient:_____

Home Phone: _____ Cell Phone: _____ Other: _____

MEDICAL HISTORY

PRIMARY CARE PHYSICIAN

Name: _____ Phone Number: _____

Address: _____

Date Last Seen: _____

PREFERRED PHARMACY

Name: _____ Phone Number: _____

Address: _____

MEDICATION LIST

1)_____ Dosage:_____ Time:_____

2)_____ Dosage:_____ Time:_____

3)_____ Dosage:_____ Time:_____

4)_____ Dosage:_____ Time:_____

5)_____ Dosage:_____ Time:_____

List All Allergies to Medication(s):

1)_____

2)_____

3)_____

4)_____

Please list any religious/personal beliefs that healthcare providers need to be aware of in addressing your care*:*

_____

_____

All medical history provided is true and accurate to the best of my knowledge.

Patient's Signature _____ **Date** _____

Insurance Information

Name of Insurance: _____ Policy#: _____ Phone Number:_____

A CURRENT COPY OF YOUR INSURANCE CARD IS REQUIRED

☐ Check here if you wish to be a cash pay patient