CHC SEK School Health

Office Use
USD: _____
Grade: _____

PATIENT REGISTRATION FORM

LEGAL FULL NAME	LAST NAME	FIRST NAME	MIDDLE NAME	PREFERRED NAME

ADDITIONAL/FORMER NAMES (EX. MAIDEN NAME)	DATE OF BIRTH (MM/DD/YY)	SSN#	
ADDRESS	CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ADDRESS)	MAILING CITY	MAILING STATE	MAILING ZIP CODE
HOME PHONE	CELL PHONE	WORK PHONE	
EMAIL ADDRESS (REQUIRED FOR PATIENT PORTAL ACCESS)		SEX ASSIGNED AT BIRTH	
PRIMARY CARE PROVIDER NAME CITY & STATE		□ Male □ Female	

RACE
(Check all that apply)

- □ **White**
- □ **Black/African American**
- □ **American Indian/Alaska Native**

Asian

- □ Asian Indian □ Japanese
- □ Chinese □ Korean
- □ Filipino □ Vietnamese
- □ Other Asian

Native Hawaiian/Pacific Islander

- □ Native Hawaiian □ Marshallese
- □ Guamanian or Charmorro
- □ Samoan □ Other Pacific Islander
- □ Decline to Specify

ETHNICITY

- □ Not Hispanic/Latino
- □ Mexican, Mexican American, Chicano
- □ Puerto Rican
- □ Cuban
- □ Other Hispanic Latino

PREFERRED LANGUAGE

- □ English
- □ Spanish
- □ Other:
- □ Interpreter Needed:

EMERGENCY CONTACT

Emergency Contact Name:

Phone:

Relationship to Patient:
□ Spouse □ Parent □ Child □ Other

Emergency Contact Name:

Phone:

Relationship to Patient:
□ Spouse □ Parent □ Child □ Other

PHARMACY

□ Apothecare Pharmacy *(CHC in-house pharmacy)*
Location:

□ Other Pharmacy

INSURANCE – CHECK ALL THAT APPLY
(PLEASE PROVIDE COPY OF CARD)

□ Medicare □ Medicare Supplement □ Medicare Advantage Plan □ Commercial Insurance
□ No Health Insurance □ Dental Insurance □ State Medicaid Kan Care, SoonerCare, MO HealthNet □ CHIP □ Other Medicaid

PRIMARY INSURANCE POLICY HOLDER

FULL NAME	DATE OF BIRTH (MM/DD/YY)
INSURANCE PLAN	SSN#
INSURANCE ID NUMBER	INSURANCE GROUP NUMBER

POLICY HOLDER'S RELATIONSHIP TO PATIENT
□ Self □ Spouse □ Parent □ Other

SECONDARY INSURANCE POLICY HOLDER

FULL NAME	DATE OF BIRTH (MM/DD/YY)
DATE OF BIRTH	SSN#
INSURANCE ID NUMBER	INSURANCE GROUP NUMBER

POLICY HOLDER'S RELATIONSHIP TO PATIENT
□ Self □ Spouse □ Parent □ Other

RESPONSIBLE PARTY

□ Check if same as patient

(PERSON RESPONSIBLE FOR PAYING PATIENT ACCOUNT)

FULL NAME	DATE OF BIRTH (MM/DD/YY)	SSN#	PRIMARY PHONE	
EMAIL	ADDRESS	CITY	STATE	ZIP CODE

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PATIENT LAST NAME: **FIRST NAME:** **DATE OF BIRTH:**

CONSENT TO TREAT

I give consent for treatment by Community Health Center of Southeast Kansas, Inc. (CHC/SEK) for medical, dental and/or mental health services. If I am consenting for a minor child, I understand that no treatment will be given without my knowledge or consent unless the treatment relates to an emergency or the treatment is otherwise permitted under applicable federal or state law.

I understand that if I am consenting to treatment of my child, if a court order has been entered with respect to the conservatorship of said child, or impacting my rights to consent to the child's care and treatment, CHC/SEK will not render services to the child until CHC/SEK has received and reviewed the most recent court order.

I understand that the information in my health record (if a mature minor) or my child's health record is confidential and will not be released to any unauthorized person or agency without consent.

I assign to CHC/SEK any and all benefits payable from any insurance provider covering the patient or person responsible for the patient's care to be paid directly to CHC/SEK which will be applied to the charges for services rendered (example: vision and hearing screenings).

I understand that CHC/SEK may disclose all or any part of the patient's medical record to any insurance company, corporation or person which is or may be liable under a contract or part of CHC/SEK's charges, including, but not limited to, medical services companies, insurance companies or pharmaceutical manufacturers.

I authorize CHC/SEK to disclose all or any portion of my health record (if a mature minor) or my child's health record to my health care provider (if a mature minor) or my child's health care provider who is: _____

I authorize CHC/SEK to disclose all or any portion of my health record (if a mature minor) or my child's health record to school personnel as it relates to my child's academic success.

I authorize CHC/SEK to examine my school records (if a mature minor) or my child's school records to assist staff in providing the necessary care for my child.

With my signature, I certify that I understand the above and that I am authorized to sign for the patient listed above on this Patient Registration/Consent for Treatment Form

_____ _____ _____ /____ /____

Signature of Patient, Agent, Representative, Parent, Legal Guardian or Responsible Party | Relationship to Patient | Month/Date/Year