



HEALTHCARE NETWORK SCHOOL BASED ENROLLMENT AND CONSENT FORM

Healthcare Network is working with your child's school to deliver healthcare services at school to provide better care for your child and to make receiving care easier. In order to participate please fill out the below forms.

PATIENT INFORMATION					
Last Name:	First Name:	Middle Name:	Suffix:	Date of Birth:	Student No.
Street Address:			SSN: _____ - _____ - _____		
City, State, Zip Code:			Sex: ☐ Male ☐ Female		
Alternative Address or PO BOX:					
Home Phone:	Mobile Phone:	Work Phone:	Email Address:		
DEMOGRAPHICS					
Preferred Language:		Race:	FQHC fields / UDS:		
☐ English		☐ American Indian Or Alaska Nat	Are you or anyone in your home an agricultural worker?		
☐ Spanish			Agricultural Worker Yes ☐ or No ☐		
☐ Creole		☐ Asian	If yes circle below		
☐ Other: _____		☐ Black or African American	- Migrant - Seasonal		
Ethnicity:		☐ Haitian	Homeless Status Yes ☐ or No ☐		
☐ Hispanic or Latino/Spanish		☐ Mexican American Indian	Public Housing Yes ☐ or No ☐		
☐ Non-Hispanic or Non-Latino		☐ Other Pacific Islander	Veteran Status Yes ☐ or No ☐		
☐ Other: _____		☐ Other Race: _____	Family Size: _____ Decline to Answer ☐		
		☐ White	Annual Income: _____ Decline to Answer ☐		
EMERGENCY CONTACT					
First and Last Name:		Relationship:	Phone Number:		
NEXT OF KIN					
First and Last Name:		Relationship:	Phone Number:		
GUARDIAN					
First and Last Name:		Relationship:	Phone Number:		
GUARANTOR					
Name:		Relationship:	Phone Number:		
Date of Birth:		SSN:	Legal Sex:		
Street Address:			City, State, Zip:		

PATIENT PREFERENCES																													
Preferred Pharmacy:	Preferred Lab:																												
COMMUNICATOR AUTOMATED MESSAGING PREFERENCES																													
We have the ability to email and/or text you. Please check the consent below and sign. *The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your cell phone carrier for pricing, plans and details). <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Health Notifications</td> <td style="width: 10%; text-align: center;">☐</td> <td style="width: 33%;">Email</td> <td style="width: 10%; text-align: center;">☐</td> <td style="width: 33%;">Phone</td> <td style="width: 10%; text-align: center;">☐</td> <td style="width: 33%;">Text Message</td> </tr> <tr> <td>Appointments</td> <td style="text-align: center;">☐</td> <td>Email</td> <td style="text-align: center;">☐</td> <td>Phone</td> <td style="text-align: center;">☐</td> <td>Text Message</td> </tr> <tr> <td>Announcements</td> <td style="text-align: center;">☐</td> <td>Email</td> <td style="text-align: center;">☐</td> <td>Phone</td> <td style="text-align: center;">☐</td> <td>Text Message</td> </tr> <tr> <td>Billing</td> <td style="text-align: center;">☐</td> <td>Email</td> <td style="text-align: center;">☐</td> <td>Phone</td> <td style="text-align: center;">☐</td> <td>Text Message</td> </tr> </table>		Health Notifications	☐	Email	☐	Phone	☐	Text Message	Appointments	☐	Email	☐	Phone	☐	Text Message	Announcements	☐	Email	☐	Phone	☐	Text Message	Billing	☐	Email	☐	Phone	☐	Text Message
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Billing	☐	Email	☐	Phone	☐	Text Message																							
Patient Signature (If a minor, signature of the guarantor or guardian)	Date:																												

HEALTH HISTORY

1. ☐ Yes ☐ No Is the child allergic to any medications/ food/ materials?
 If yes, please explain:_____
2. ☐ Yes ☐ No Is the child taking any medications?
 If yes, please list:_____
3. ☐ Yes ☐ No Is the child currently being treated for any illnesses?
 If yes, please explain:_____
4. ☐ Yes ☐ No Has the child ever had any serious illness/ been hospitalized?
 If yes, please explain:_____
5. ☐ Yes ☐ No Has the child ever had a blood transfusion?
6. ☐ Yes ☐ No Is the child physically mentally, or emotionally impaired?
7. ☐ Yes ☐ No Are the child's teeth brushed daily?
 How many times?_____
8. ☐ Yes ☐ No Is fluoride toothpaste used?
9. ☐ Yes ☐ No Has the child had any injuries to mouth, head, or teeth?
10. ☐ Yes ☐ No Does the child suck thumb, finger, or pacifier?
11. ☐ Yes ☐ No Has the child had any orthodontic treatment/ consultations?
12. ☐ Yes ☐ No Is your child currently experiencing dental pain/ discomfort)?

Has your child had any history of, difficulty with, or diagnosis of the following (check applicable boxes):

- | | | | |
|---|--|--|--|
| ☐ Heart Murmur | ☐ Cancer | ☐ Hearing | ☐ Heart problems |
| ☐ AIDS/HIV | ☐ Drug Abuse | ☐ Hepatitis/Liver Disease | ☐ Pregnancy |
| ☐ Anemia | ☐ Diabetes | ☐ High Blood Pressure | ☐ Radiation/ Chemotherapy |
| ☐ Arthritis | ☐ Epilepsy | ☐ Joint Replacement | ☐ Rheumatic Fever/ |
| ☐ Bone / Joint | ☐ Fainting/Seizures | ☐ Kidney Problems | ☐ Sickle Cell Anemia |
| ☐ Asthma | ☐ Cerebral palsy | ☐ Latex Allergy | ☐ Tobacco Use / Smoking |
| ☐ Bleeding Disorders | ☐ Growth problems | ☐ Mental Health Problems | |
| ☐ Other problems:_____ | | | |

INSURANCE INFORMATION

Insurance Information (If Your Child Has Medicaid):

Medicaid Provider: _____ **Medicaid #:** _____

Insurance Information (If Your Child Has Private Insurance):

Insurance Name: _____ **Insurance Phone #:** _____

Policy Holder's Name: _____ **Employer:** _____

Policy Holder ID or SSN: _____ **Group #:** _____

Policy Holder Birth Date: _____ **Holder Phone #:** _____

Insurance Information (If Your Child Has Private Dental Insurance):

Insurance Name: _____ **Insurance Phone #:** _____

Policy Holder's Name: _____ **Employer:** _____

Policy Holder ID or SSN: _____ **Group #:** _____

Policy Holder Birth Date: _____ **Holder Phone #:** _____

Sliding Fee Scale Program:

Healthcare Network offers a sliding fee scale program for individuals who qualify financially. Please reach out to us at 239-658-3000 with any questions or check our website for more information, www.HealthcareSWFL.org.

CONSENT AND AUTHORIZATION

By signing this form below I understand that I am consenting to and authorizing the following:

1. I authorize Healthcare Network, its facilities or treatment centers, its affiliated physicians, dentists, behavioral health providers, and other medical personnel in charge of my or my child's care, to administer examinations and treatments, as may be deemed medically necessary in the exercise of their professional judgement. This includes, but is not limited to, well visits, sick visits, medication management, and emergency visits.
2. I authorize Healthcare Network to immunize my child and/or administer a flu shot if necessary.
3. I authorize Healthcare Network to provide dental, medical, and behavioral health screenings for my child.
4. I authorize Healthcare Network to provide behavioral health treatment for my child.
5. I authorize the release of information regarding my child's information to my insurance or Medicaid provider so that Healthcare Network may submit claims.
6. I acknowledge receipt of Healthcare Networks notice of privacy practices and patient rights found at www.HealthcareSWFL.org/patient-rights/.
7. I authorize Healthcare Network to utilize Surescripts, Inc., to lookup past/present prescriptions that my child is prescribed.
8. I understand that the healthcare records for my child will be kept separate from school records and that if I need a copy I will need to contact Healthcare Network.
9. I understand that Healthcare Network will make best efforts to reach me via telephone whenever my child is being seen, but that if I am unreachable I am authorizing Healthcare Network to provide the care outlined above.

If you wish to specifically exclude consent/authorization for a number above or a specific service please list it here: _____

Please note that not consenting/authorizing certain aspects of care may limit Healthcare Networks ability to provide your child with care. You have the right to revoke this authorization at any time, to do so please call Healthcare Network at 239-658-3000.

Signature

Printed Name

Relation to Patient

Date