Mallory Community Health Center
School-Based Registration Form

Please Check One: ☐ *New Student* ☐ *Existing Student*

Student's Information (Please print clearly)

Legal Name: _____ (Last) _____ (First) _____ (Middle Name)

Date of Birth (mm/dd/yy) ____/____/____ | Social Security # ____-____-____ | Mother's Maiden Name: _____

Student's Contact Information

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone:	Cell Phone:	Work Phone:	Email address:	Communication Preferences: Check all that apply:
_____	_____	_____	_____	☐Mail ☐Patient Portal ☐Email ☐ Primary phone
Ok to leave a voicemail? ☐ Yes ☐ No	Ok to leave a voicemail? ☐ Yes ☐ No	Ok to leave a voicemail? ☐ Yes ☐ No	Would you like to sign up for the Patient Portal? ☐ Yes ☐ No	

Student's Emergency Contact

Name: _____
Address: _____
Phone _____
Relationship to student _____

Student's Preferred Language

☐ English ☐ Spanish ☐ Chinese
☐ French ☐ Japanese ☐ Korean
☐ Vietnamese
☐ Need an Interpreter
☐ Other _____

Student's Preferred Pharmacy

Pharmacy Name: _____
Pharmacy Address: _____
Pharmacy Phone: _____

Student Demographic Information

Marital Status:
☐ Married ☐ Partnered
☐ Single ☐ Divorced
☐ Separated ☐ Widow

Race:
☐ Black/African American ☐ White
☐ Hispanic ☐ Asian
☐ Pacific Islander ☐ Native Hawaiian
☐ American Indian/Alaskan Native ☐ More than one race
☐ Other _____

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown
☐ Decline to specify
☐ Other _____

Gender:
☐ Male
☐ Female

Student School Name & Grade

School Name: _____
Grade: _____

Income

☐ 0 - $14,580 ☐ $14,581 - $19,720 ☐ $19,721 - $24,860
☐ $24,861 - $30,000 ☐ $30,001 - $35,140 ☐ $35,141 - $40,280
☐ $40,281 - $45,420 ☐ $45,421 - $50,560 ☐ $50,561 - $99,999

Household Size

Number of people in household _____

"ALL FAMILY MEMBERS OVER THE AGE OF 21 LISTED ABOVE MUST PRESENT INCOME OR A NOTARIZED LETTER STATING HE/SHE HAS NO INCOME AND LIVE WITH YOU FREE OF CHARGE"

Insurance Information: What Health Insurance Coverage Do You Have? Please check all that apply.

☐ Medicaid ☐ Medicare ☐ Private Health Insurance ☐ Dental ☐ Uninsured

Primary Insurance Name _____ Policy Number: _____ Group # _____
Secondary Insurance Name _____ Policy Number: _____ Group # _____
Dental Insurance Name _____ Policy Number: _____ Group # _____
Medicaid Number: _____ Medicare Number: _____

Parent or Legal Guardian Information and Consent

Parent or Guardian: _____ Phone No. _____ Social Security No. _____ Birth Date _____

☐ Yes, I would like my child to be assessed and treated for medical and dental services by Mallory Community Health Center.

☐ No, I would not like my child to be assessed and treated for medical and dental services by Mallory Community Health Center.

Signature of Parent or Legal Guardian: _____ Date: _____

Please list any medications your child is taking: _____

Is your child's immunization record current and up to date? ☐ Yes or ☐ No

Family Health History: Does anyone in your child's family have the following? Check all that apply.

- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Cancer
- ☐ Diabetes
- ☐ Nervous/Mental Problems
- ☐ Kidney Disease
- ☐ Seizures Disorder
- ☐ Arthritis
- ☐ Sudden Death
- ☐ Sickle Cell Anemia

Child's Health History: Does your child's family have the following? Check all that apply.

- ☐ Chicken Pox
- ☐ Asthma
- ☐ Communicable Disease
- ☐ Meningitis/Encephalitis
- ☐ Tonsillitis
- ☐ High Blood Pressure
- ☐ Heart Disease/Heart Murmur
- ☐ Respiratory Disease
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Seizures (fits/convulsions)
- ☐ Major Injuries
- ☐ Behavior Problems
- ☐ Speech Problems
- ☐ Diabetes
- ☐ Birth Defects
- ☐ Sickle Cell Disease
- ☐ Sickle Cell Trait
- ☐ Eating Problems
- ☐ Allergy to Novocain or Dental Anesthesia
- ☐ Food or Drug Allergy; List: _____

Acknowledgement of Receipt of Mallory Community Health Center Notice of Privacy Practices

I acknowledgement that I have received a copy of the Mallory Community Health Center notice of privacy practices.

Print Name: _____ **DATE:** _____

SIGNATURE: _____

GENERAL CONSENT FOR INSURANCE, DIAGNOSIS AND TREATMENT

I, the patient or parent / guarantor, hereby authorize any holder of information about me or any information needed for settlement of claims to be released to Medicaid, Medicare, or Insurance Provider. I understand approved claims will be deducted from my allocated benefits whether they were rendered in one our clinics or mobile health family. I request that all health insurance benefit payments be made on my behalf to Mallory Community Health Center (MCHC). I understand that MCHC will not be responsible for hospitalization charges, nor will be responsible for other services rendered outside of MCHC. I grant permission for MCHC to furnish the patient records, requested information, or excerpts to medical service centers, third party payer (for billing purposes) and requisite legal health or social services facilities. Permission is hereby granted to release medical records to the MCHC from any and all hospitals, clinics, and physicians of which I have received medical/dental care.

Having registered with MCHC, I, the undersigned patient or responsible person, understand that this registration form is valid, and services will continue as long as I or my child is enrolled in this school or until I decide to opt-out by sending a written notice to discontinue services. My signature is my authorization to bill on my behalf. My signature also serves as authorization for service and treatment. I may provide a written notice to dismiss this authorization to Mallory Community Health Center at any time. I understand that Mallory Community Health Center will be providing Early Periodic Screening, Diagnostic, and Treatment Services (EPSDT), Medical Services, and Dental Services for children and adolescents through our School-Based clinics. Screenings include the following services:

- Complete Physical Assessments (including sports physicals)
- Vision and Hearing Screenings; Wellness screening labs (as indicated for age)
- Dental Assessments, Treatment, and Referrals
- Developmental and Behavioral Screenings and Evaluations and Depression Screenings (age specified)
- Parent and Child Health Education
- Referrals for Health Services

Print PARENT/GUARDIAN Name: _____ **Child's Name** _____

PARENT/GUARDIAN SIGNATURE: _____ **Date:** _____