my health e schools

ADULT PATIENT REGISTRATION The Center for Rural Health Innovation

Patient's Name (First, Middle, Last):_____ Nickname:_____

DOB:_____ SSN:_____ Male or Female Age:_____ Zip: _____

Mailing Address: _____ City: _____ State: _____

Home Phone: _____ Cell Phone:_____ Email: _____

Marital Status: (circle) Married Single Divorced Separated Widowed Minor/Child Student: Y or N FT or PT School:_____

Employer:_____ Phone:_____

Spouse Name & Ph:_____ DOB:_____ SSN:_____

In Case of Emergency, please tell us a Local Friend or Relative (not living at same address) whom we could contact.

Name:_____ Relationship:_____ Ph:_____

Primary Care Provider and other relevant Clinicians: _____

Person Responsible for the Bill:_____

Is the Patient covered by insurance? YES or NO. If NO: ____ Level A ____ Level B ___ Level C (consult sliding fee scale)

Please fill in all of the following:

Primary Insurance Name of Insurance Company: _____ CoPay Amount: _____

Ins. ID Number: _____ Group Number: _____

Name of Subscriber:_____ DOB:_____ SSN:_____

Patient's Relationship to Subscriber: SELF SPOUSE CHILD OTHER:_____

Secondary Ins. Name of Insurance Company: _____ CoPay Amount: _____

Ins. ID Number: _____ Group Number: _____

Name of Subscriber:_____ DOB:_____ SSN:_____

Patient's Relationship to Subscriber: SELF SPOUSE CHILD OTHER:_____

The above information is true and complete to the best of my knowledge.

I, the undersigned:

- give permission and consent to have treatment through and by MY Health-e-Schools. I understand the nature of this treatment, the way it is provided, and the details and limitations of this form and style of treatment.
- acknowledge that I have been offered a copy of the Notice of Privacy Practices (available on our website www.myhealtheschools.org or at the school nurse office).
- agree that all I will be responsible for all costs associated with said treatment and that I will provide any insurance information as requested. All costs and fees not covered by insurance will be my responsibility. Additionally, I authorize the release of any information necessary to process insurance claims for payment of benefits to MY Health-e-Schools, and authorize the payment of insurance benefits to MY Health-e-Schools for services rendered.
- agree to release all records related to this treatment to the parties listed above: (ex: Primary Care Provider)

_____ _____

Patient Signature Date

MY Health-e-Schools Adult Health Questionnaire

_____ _____ _____
Last Name First Middle

_____ ____Male ____Female
Date of Birth

Are you allergic to any medications?

___ Yes - *Please list* _____
___ No

Are you on any medications and/or supplements?

___ Yes - *Please list* _____
___ No

Do you have any of the following conditions or other health concerns: - *Include details*:

___ Yes ___ No: **Allergies**, other than medications (such as bee stings or peanuts) _____
___ Yes ___ No: **Asthma** _____ *Date of last asthma attack* _____
___ Yes ___ No: **Seizures** _____ *Date of last seizure* _____
___ Yes ___ No: **Vision Problems** _____
___ Yes ___ No: **Hearing Problems** _____
___ Yes ___ No: **Heart Problems** _____
___ Yes ___ No: **Bleeding Disorders** _____
___ Yes ___ No: **Orthopedic (bone or joint) Problems** _____
___ Yes ___ No: **Anxiety/Depression** _____
___ Yes ___ No: **Operations** _____
___ Yes ___ No: **Hospitalizations** - *Dates (details below)* _____
___ Yes ___ No: **Frequent absences from work or disruption from daily activities** *(Details below)*
___ Yes ___ No: **Other**_____
Additional Details:_____
_____
_____
_____

Tobacco Use:
Do you smoke cigarettes? ___-Never ___-No ___-Yes
Approx. how many packs a day do you smoke? _____
Other: ___-Pipe, ___-Cigar, ___-Snuff, ___-Chew

Alcohol Use:
Do you drink alcohol? ___-No ___-Yes
How many drinks per week? _____

In signing this form, I am stating the following:

- *The information that I have provided is accurate and up-to-date.*
- *I will update MY Health-e-Schools with any changes as soon as possible.*

If you would like to speak with our medical provider about any of your health issues or concerns, please contact MY Health-e-Schools at (828) 467-8815.

_____ _____
Signature Date