COPLIN HEALTH SYSTEMS

Patient Name: _____ Date of Birth: _____

## School-based Health Enrollment Form

Date of Birth: _____ Sex: ☐ Male ☐ Female ☐ Unknown Student SS #: _____
Student name: _____ Preferred Name: _____
Street Address: _____ City/State/Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
School: _____ Grade: _____
**Communication Preference:** (*for appointment reminders etc.*) ☐ Voice ☐ Text ☐Email
Email: _____ ☐ Does not have email ☐ Will not disclose ☐ Other
Employer/School: _____ Phone: _____
Preferred Provider: _____ Primary Care Provider: _____
I was referred to Coplin Health Systems by (Individual or Doctor): _____
**Language:** ☐ English ☐ Spanish ☐ Other _____ ☐ Translator needed
**Responsible Party:** (Responsible for Bill) ☐ Same as above
Name: _____ Birthdate: _____
Mailing Address: _____ City/State/Zip: _____
Home Phone: _____ Cell: _____ Work: _____
Relationship to Patient: _____

## Parent/Guardian Information (court issued guardian/custody documentation is required)

Father: _____ (email) _____
Phone (H)_____ (W)_____ (C) _____
Mother: _____Maiden Name: _____(email) _____
Phone (H)_____ (W)_____ (C) _____
Guardian: _____(email) _____
Phone (H)_____ (W)_____ (C) _____

**EMERGENCY /ALTERNATE CONTACT INFORMATION: I understand that by providing an alternate contact if I cannot be reached, medical information regarding the above-named child will be shared between the medical provider and the alternative contact (including all relevant information with exception to psychiatric/mental health, alcohol/drugs, and HIV / AIDS information).**

Name: _____Relationship: _____
Address: _____
May we leave a message? __ Y __N
Phone: (Home) _____ Work) _____ (Cell)_____

I, _____, Authorize Coplin Health Systems to share my personal health information with the named persons below. (Please **circle** which information Coplin Health Systems is authorized to share with each named person)

Name: _____ Date of Birth _____ Relationship to Patient: _____
Phone: _____ Medical Dental Billing Scheduling Behavioral Health SUDS HIV/AIDS ALL

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## Insurance Information- Please write any additional information the back of form.

☐ **Primary Health Insurance:** Name of Insured Parent / Guardian_____
Date of Birth of Card Holder_____ SSN of Card Holder _____
Address (if different from child):_____
Place of Employment _____
Name of Insurance Company _____
ID Number _____
Group Number _____

☐ **Secondary Health Insurance**: Name of Insured Parent / Guardian_____
Date of Birth of Card Holder_____ SSN of Card Holder _____
Address (if different from child):_____
Place of Employment _____
Name of Insurance Company _____
ID Number _____
Group Number _____

☐ **Dental Insurance**: Name of Insured Parent/Guardian:_____
Date of Birth of Card Holder_____ SSN of Card Holder _____
Address (if different from child):_____
Place of Employment _____
Name of Insurance Company _____
ID Number _____
Group Number _____

☐ **Secondary Dental Insurance**: Name of Insured Parent/Guardian:_____
Date of Birth of Card Holder_____ SSN of Card Holder _____
Address (if different from child):_____
Place of Employment _____
Name of Insurance Company _____
ID Number _____
Group Number _____

☐ **Student has no health insurance**
☐ **Request application for sliding fee.**
☐ **I want assistance from Coplin Health Systems to obtain insurance.**

- I agree to allow Coplin Health Systems access to my prescription history: ☐ Yes ☐ No
- I agree to leave my credit/debit card on file: ☐ Yes ☐ No
- I agree to have nursing and/or medical students present during my care: ☐ Yes ☐ No

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## Current Medications & Health information

| | | |
|---|---|---|
| Medication: | Dose (mg): | Directions: |
| Medication: | Dose (mg): | Directions: |
| Medication: | Dose (mg): | Directions: |
| Medication: | Dose (mg): | Directions: |

1. Doctor's name: _____ Date of last well-child exam: _____
2. If your child has not seen a doctor within the last year, would you like your child to have a well-child exam at our wellness center? **Yes or No**
3. If we need to call in a prescription, which pharmacy would you like us to call? _____

## Portable Dental Unit

The portable dental unit visits schools twice a year (fall and spring) for dental exams, fluoride treatments, cleaning, and sealants. **Please note if your child has an appointment and the forms are not signed and returned for each dental visit, the appointment will be canceled. If your child is going to another dentist and does not need these services, please mark "no" below**.

Services utilized through the Portable Dental Unit will be billed to your insurance. If you do not have coverage, the sliding fee scale will provide a discount for your child to be seen by the dentist. To see if you qualify for this reduced rate, you must complete the income section of the enrollment.

**If your child already has a dentist, he/she does not qualify for this program. Your insurance will not cover the fees of both your regular dentist *and* this program.**

Name of Current Dentist: _____ Date of last dental exam: _____

If your child has not seen a dentist in the last year, would you like your child to have a dental cleaning at our Wellness Center? ☐**Yes or** ☐**No**

If yes, do you want your child to have dental sealants on the same day as cleaning? ☐**Yes or** ☐**No**

## Social Demographic Survey

Coplin Health Systems is a Federally Qualified Health Center, and we qualify for special pricing and discounted costs to our patients. To ensure that we continue to receive this designation and funding, we must report specific information about the population that we serve. We ask that you assist us by completing the following information.

**How many people are currently living in your household?**
**(Circle the correct answer)** 1 2 3 4 5 6 7 8 9

**What is your estimated household monthly net income?**
$100–500 $501-$1000 $1001 –$1500 $1501-$2000 $2001-$2500 $2501-$3000
$3001-$3500 $3501-$4000 $4001-$4500 $4501-$5000 $5001-$5500 $5501- $6000

**Household Status**: ☐ Own my home ☐ Rent ☐ Live with someone ☐ In Shelter ☐ Transitional ☐ Homeless

**Gender** (circle one): Female, Male, Transgender Male, Transgender Female, Other, Choose not to disclose

**Sexual Orientation** (circle one): Straight, Lesbian/Gay, Bisexual, Other, Don't know, Choose not to disclose

**Military Status:** ☐ Not a Veteran ☐ Veteran ☐ Active Service

**Disability Status:** Do you have a disability as identified by the Americans with Disabilities Act? ☐ Yes ☐ No

**Race**: (circle one) *White, Black, American Indian/Alaskan Native, Native Hawaiian, Pacific Islander, Asian, Native American, or Other if so list:* _____

**Ethnicity**: (circle one) Not Hispanic/Latino, Hispanic/Latino, Decline to Specify, Other:_____

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## Consent for Services

I, the legal parent/guardian, with my signature on this form, give consent for my child to receive services at Coplin Health Systems. I have read, understand, and agree to all the above as I have selected. The information is correct to the best of my knowledge. I understand that this consent form will be good for one year or until I provide Coplin Health Systems with written directions otherwise, whichever is shorter. By signing the consent form, I am giving Coplin Health Systems, the school nurse, and my child's regular doctor (if applicable) permission to communicate and share medical information regarding this applicant's medical condition on an as-needed basis with the understanding that this information will continue to be treated confidentially. No student will be denied access to health care services due to the inability to pay. As in any health center, there may be a charge depending on the service provided. I agree that when available, my insurance or Medicaid can be billed. The health center may release information regarding treatment to third-party payors for billing purposes. I understand that I am financially responsible for any balance. I understand and agree to the financial policy. Confidentiality between the student, parents, and the health center is assured. I understand how to obtain a copy of the Notice of Privacy Practices from a Patient Representative, viewed on the lobby wall, or on the website at *www.coplinhealth.com*. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur for my treatment, payment of bills, or in the performance of Coplin Health Systems' care operational and other purposes that are permitted and required by law. It also describes my rights to access and control my protected health care information. I understand and agree for my information will be shared with the WV and OH Health Information Networks; if I want to remove this access, I understand that I will need to provide a written statement to opt out. I agree that by providing contact information, Coplin Health Systems may contact me or those listed above. I understand that if guardianship changes, the legal guardian must sign a new consent. The documentation for guardianship and custody must be provided with the registration form and anytime there are updates.

**If you selected to have your child receive cleanings and/or sealants, signing this enrollment form will provide consent for him/her to participate in the portable dental services and confirms that your child does not already have a dentist.**

Coplin Health Systems is a Federally Qualified Health Center (FQHC), and as such we qualify for special pricing and discounted costs for our patients.

_____ _____

**Printed Name of Patient or Responsible Party** **Printed Patient Name (if Different than Responsible Party)**

_____ _____

**Signature of Patient or Responsible Party** **Date**