Community Health Center of Southeast Kansas

School Health

Thank you for choosing CHC/SEK for your child's health care needs. The School Health clinic is available for all district students. Please provide the information below so we may care for your child. Please note that all information provided by you will be kept strictly confidential in compliance with Federal privacy laws. If you have any questions or need assistance, please ask the receptionist or call 620-231-9873. *Please complete this form in ink.*

PATIENT INFORMATION

Full Legal Name

Last Name:	First:	Middle:

Mailing Address_____ City _____

State & Zip_____

Home Number_____ Cell Phone_____ Work Phone_____

Preferred method of communication for appointment reminders: ❑ Text ❑ Phone Call

Date of Birth_____ Male❑ Female ❑ Social Security Number_____

Marital Status:
❑Divorced
❑Married
❑Partner
❑Single
❑Widowed
❑Legally Separated

Employment Status:
❑Full-time Employment
❑Part-time Employment
❑Unemployed
❑Self-Employed
❑Retired

Student Status:
❑Full-time Student
❑Part-time Student
❑Not in School

School Name: _____

Grade: _____

RESPONSIBLE CAREGIVER (Children under 18 years of age OR Adults with Durable Power of Attorney)

Name_____Mailing Address_____

City, State, Zip_____

Relationship to Patient_____Birth Date_____Social Security #_____

EMERGENCY CONTACT

In the event of an emergency, who should we contact? _____

Relationship?_____

Home #_____ Cell #_____ Work #_____

Please Complete the Back of Form

INSURANCE INFORMATION

Check all that apply:

❑No Health Insurance

Would you like to meet with a patient navigator to see if you are eligible for Medicare Part D, Medicaid or Insurance Market place? Yes ❑ No ❑

❑KanCare (Amerigroup, Sunflower, United HealthCare)

❑Other Medicaid (Oklahoma or Missouri)

❑Motor Vehicle Accident

❑Commercial Insurance ❑Other Accident

Provide insurance information below.

Please provide the front desk your insurance card for billing purposes.

Primary Insurance	**Secondary Insurance**
Insurance Plan_____	Insurance Plan_____
Member ID Number _____	Member ID Number _____
Group Number _____	Group Number _____
Policy Holder Information:	**Policy Holder Information:**
Full Name _____	Full Name _____
Date of Birth _____	Date of Birth _____
Social Security Number _____	Social Security Number _____
Relationship to Patient _____	Relationship to Patient _____
Employer _____	Employer _____

E-Mail Address_____

Race:
❑American Indian/Alaskan
❑Asian
❑Native Hawaiian
❑Black or African American
❑White
❑Hispanic
❑Other Race
❑Pacific Islander

Ethnicity:
❑Hispanic/Latino
❑Not Hispanic/Latino

Preferred Language
❑English
❑Spanish
❑Other _____

Veteran:
❑Yes
❑No

If you are Homeless, are you:
❑On the Street
❑Doubling Up
❑In Transitional Housing
❑In a Shelter
❑Other

Have you or has anyone in your household worked in agriculture, such as planting, cultivating, or harvesting (fruits, vegetables, grains, or dairy) in the last 2 years as a:

❑Seasonal Worker
❑Migrant Worker

Pharmacy:_____ _____
Name City & State

Community Health Center of Southeast Kansas

SCHOOL HEALTH CONSENT FOR TREATMENT AND INSURANCE BILLING

Please Read and Sign Below.

I give consent for treatment by the Community Health Center of Southeast Kansas for medical, dental and/or mental health services. I understand that services are available without discrimination prohibited by federal and state law. If consenting for a minor child, I understand that no treatment will be given without my knowledge or consent unless it is an emergency.

- I understand that the information in my (if a mature minor) or my child's medical 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.
- I understand that vision and hearing screenings may be billed to my insurance carrier.
- 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 (if a mature minor) or my child's health record to my (if a mature minor) or my child's medical provider who is _____.
- I authorize CHC/SEK to disclose all or any portion of my (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 (if a mature minor) or my child's school records to assist staff in providing the necessary care for my child.
- If there are services you would like to opt out of, please list them here:

  _____

With my signature, I certify that I understand the above and that I am authorized to sign for the patient.

_____

Signature of Patient, Agent, Representative, Parent, Legal Guardian or Responsible Party

_____ _____

Relationship to Patient Date

Printed Student Name:_____ Student Date of Birth: _____

2/2017