



Teen Health Center, Inc.

Providing free medical and mental health care to Galveston County youth since 1985

PATIENT INFORMATION

Patient's Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth _____ (MM/DD/YYYY) Sex: ___ Male ___ Female

School: _____ Grade: _____

Ethnicity: ___ Hispanic ___ Black ___ White ___ American Indian ___ Asian/Pacific Islander ___ Other _____

Patient Address: _____

Street Address City State Zip Code

Telephone Home: _____ Work: _____ Cell: _____

Email address: _____

Who is the patient's regular doctor?

Name: _____ Telephone: _____

Address: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____ Relationship to Patient: _____

Telephone Home: _____ Work: _____ Cell: _____

INSURANCE INFORMATION

Do you have Medicaid?

___ No ___ Yes: Medicaid ID # _____

Do you have other insurance?

___ No ___ Yes: Name _____

Coverage Number: _____

PATIENT MEDICAL HISTORY

Do you have any allergies to medicine?

___ No ___ Yes

If yes, please describe: _____

Please state the medications you take: _____

Do you have allergies, sensitivities, or reactions to any substances such as food, mold, pollen, animal dander, dust or insects? No Yes

Do you have asthma? No Yes

Have you ever had a seizure? No Yes

Do you have diabetes? No Yes

Do you have any known heart condition? No Yes

Have you ever had to stay overnight in the hospital? No Yes

Have you ever had surgery? No Yes

Have you suffered from any trauma or severe injury? No Yes

Have you had any mental health issues? No Yes

Do you have any other health problems? No Yes

Please explain any "yes" responses: _____

FAMILY HEALTH AND SOCIAL HISTORY

Has any family member had heart disease before age 50? No Yes

Does any family member have Tuberculosis (TB)? No Yes

Have there been any mental health issues in the family? No Yes

Does any family member smoke tobacco in the home? No Yes

Please explain any "yes" responses: _____

AUTHORIZATION FOR SPECIFIC HEALTH CARE SERVICES

Please complete:

- **Yes or No** (Please Circle One) – I consent to receive routine physical examinations, weight/fitness program, TB skin test, immunizations, management of minor illnesses and injuries - including laboratory tests and medications, and general health education.
- **Yes or No** (Please Circle One) – I consent to receive counseling for the treatment of mental health and developmental conditions, which may include evaluation, diagnosis, and if necessary, referrals.
- **Yes or No** (Please Circle One) – I consent to receive medications for the treatment of mental health and developmental conditions, which may include evaluation, diagnosis, and if necessary, referrals. Services may be provided by telemedicine.
- **Yes or No** (Please Circle One) – I consent to receive counseling and testing for the HIV/AIDS virus.
- **Yes or No** (Please Circle One) – I consent to receive reproductive services including family planning, birth control, distribution of condoms, and screening for sexually transmitted infections.
- **Yes or No** (Please Circle One) – I consent for The Teen Health Center, Inc. to take my photo to place in the electronic medical record.

PERMISSION FOR SCHOOL-BASED HEALTH CENTER SERVICES

I have read and understand the services listed above. My signature indicates my desire to receive the services I circled above from the Teen Health Center, Inc. I understand that confidentiality between the patient and the health provider will be ensured in accordance with the law. In the event of an emergency situation, I realize it may be necessary for the Teen Health Center, Inc to release my health information to the school district (i.e., Texas City or Galveston Independent School District) where my clinic is housed. This sharing of information is needed to protect my health and safety. I also realize that the Teen Health Center may share information with the school nurse to ensure that my vaccines are up to date. Separate authorization is required for sharing additional health information. I understand this information will remain confidential in accordance with federal and state laws.

My signature also indicates that I am aware that my health information may be released as indicated above and that I have been given the opportunity to review the Notice of Privacy Practices.

X _____
Signature of Patient _____
Date

Check box if you do not want to receive information via email or mail from the Teen Health Center, Inc.

Tor Health Clinic
Ball High School
409.766.5750

Austin Health Clinic
S.F. Austin School
409.761.3516

Central Health Clinic
Central Middle School
409.761.6216

La Marque Health Clinic
La Marque High School
Coming Soon

Texas City Health Clinic
Calvin Vincent ECC
409.916.0720