



PATIENT INFORMATION

Patient's First Name: _____ Middle Name: _____ Last 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 medical services such as 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.

PERMISSION FOR SCHOOL-BASED HEALTH CENTER SERVICES

Permission

I have read and understand the services listed above. My signature provides permission to receive the services I have circled above from the Teen Health Center.

Confidentiality

I understand that confidentiality between the patient and the health provider will be ensured in accordance with the law. Teen Health Center works collaboratively with teaching hospitals and Universities. There may be times when

learners (e.g., medical students, residents, graduate students) participate in patient care. The same HIPAA policies apply to these learners and confidentiality will be maintained.

Sharing of Information

In the event of an emergency, I realize it may be necessary for the Teen Health Center, Inc to release my health information to the school district where this clinic is housed (Galveston Independent School District). 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. Teen Health’s Notice of Privacy Practices will be given to patients at their first appointment, is available any time upon request, is publicly posted in all clinics, and is available for download at www.teenhealthcenter.org. My signature below 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.