120 Oak Avenue, Spruce Pine NC 28777 828.467.8815
8:00 am – 3:00 pm Monday-Friday throughout the school year
Health-e-schools.com

PATIENT INFORMATION

Legal Name: _____
First Middle Last
Preferred Name: _____ DOB: ____/____/____ Sex: M F SSN: ____-____-____

Mailing Address: _____
City State Zip
Preferred Contact #: _____ Cell / Home Alt Phone #: _____ Cell / Home / Work

I wish to receive my appointment reminders via (only circle one): PHONE TEXT E-MAIL
I authorize HES to leave messages on answering machine/voicemail of phone numbers listed above: YES NO

School Attending/Employed: _____ *(circle one)* Student Staff/Faculty

Primary Care Physician: _____ City:_____ Date of last physical:_____

Dentist: _____ City:_____ Date of last dental exam:_____

Preferred Pharmacy: _____ City: _____

Language: _____ Race: _____ Ethnicity: Hispanic/Non-Hispanic

Marital Status: Married/Single/Divorced/Widow Email: _____

Emergency Contact: _____ Relationship to patient: _____

Emergency Contact phone number: _____ Alt phone number: _____

PERSON RESPONSIBLE FOR PATIENT'S ACCOUNT (i.e. Guarantor, Parent, Guardian, etc.)

Legal Name: _____
First Middle Last
Relationship to patient: _____ DOB: ____/____/____ Sex: M F SSN: ____-____-____

Mailing Address: _____
City State Zip

Contact phone number: _____Cell/Home Alt phone number: _____Cell/Home/Work

INSURANCE

Primary Insurance:
Subscriber's Name: _____
First Middle Last
Relationship to patient: _____ DOB: ____/____/____ SSN: ____-____-____

Insurance Company: _____ Policy ID #: _____ Group #:_____

Secondary Insurance if applicable:
Subscriber's Name: _____
First Middle Last
Relationship to patient: _____ DOB: ____/____/____ SSN: ____-____-____

Insurance Company: _____ Policy ID #: _____ Group #:_____

If no insurance please circle YES

MEDICAL HISTORY

NAME (First): _____(M)____(Last): _____DOB:_____

Known Drug Allergies: _____

Allergies other than medications (such as peanuts, bee stings, etc.)_____

Please list ALL medications that patient is on, including prescriptions, vitamins and over-the-counter drugs

Medications/What do you take if for?	**Dosage**	**How often**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any **past** medical conditions please list: _____

_____

Any **current** medical conditions please list: _____

_____

Surgeries (list with dates):_____

Hospitalizations (list with dates):_____

Family History (list condition and relationship with patient):_____

_____

Is the patient exposed to tobacco? _____what kind:_____how much:_____

Is the patient exposed to alcohol? _____what kind:_____how much:_____

AGREEMENT

HIPAA/FERPA: Health-e-Schools staff will share confidential information only in the following situations: when it is educationally relevant for a student's academic progress, when necessary to address potential health care needs, to ensure the safety of the patient, other students/staff/and/or school personnel, or other situations specified by law. The Health-e-Schools staff may discuss the patient's medication and other health case needs with the appropriate staff members who will administer the student's medication and provide care to the student while the student is at school. Additional detailed information about the Privacy Practices that govern the Health-e-Schools Telemedicine Program is available on our website at www.health-e-schools.com and at each school nurse office.

I, the undersigned, give permission and consent for the above enrolled patient to have treatment through and by 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. I give permission for Health-e-Schools to receive information from the school about my child's health history if appropriate. I acknowledge that I have been offered a copy of the Notice of Privacy Practices. I agree to release all records related to this treatment to the Primary Care Provider. I agree that 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. As the undersigned of the above patient, I authorize the release of any information necessary to process insurance claims for payment of benefits to CRHI for Health-e-Schools. The information above is true and complete to the best of my knowledge.

By signing this form I am stating the information I am providing is accurate and up-to-date, and I will update Health-e-Schools with any changes as soon as possible. This form is valid until written revocation is received by Health-e-Schools staff or student/staff is no longer enrolled in the school system.

Signature:_____ **Date:**_____

If you would like to speak with our medical provider, please contact Health-e-Schools at (828) 467-8815.