Region 9 School Based Health Center

PATIENT REGISTRATION AND CONSENT FOR SERVICES

STUDENT INFORMATION

Patient Name (last, first, middle)	Date of Birth	Grade
Patient Address (street, city, state, and zip)	Patient Phone	Patient Email Address
Parent(s)/Legal Guardian(s) Name(s)	Patient Sex (circle one) Male Female	
	Patient Race (circle one) Black Native American/Alaska Native Hispanic White Other	
Parent(s)/Legal Guardian(s) Address (street, city, state and zip)	Parent/Guardian Phone	Parent/Guardian Email Address
Emergency Contact Person Name and Relationship to Patient	Emergency Phone	

INSURANCE INFORMATION

Primary Care Physician	Primary Care Physician Phone Number
Primary Care Physician Address	
Does the patient have Medicaid? YES NO If Yes, please circle provider below.	
Blue Cross/Blue Shield Centennial Western Sky Community Care New Mexico Medicaid Presbyterian Centennial	
Medicaid Number:	

HEALTH HISTORY

List any allergies	List any surgeries When/Where	List Hospitalizations When/Where	List Current Medications/ Dosages

List any family health conditions which may be inherited (i.e. high blood pressure, heart disease):

PARENT/GUARDIAN CONSENT

--By signing below, I give permission for my child, named above to recieve SBHC services and for SBHC staff to access my child's class schedule (for appointment purposes only.) Services include, but are not limited to, comprehensive risk screenings, mental health counseling, and physical health care.

--I give permission for my student to be seen via telemedicine when necessary and appropriate. I also give permission for the SBHC staff to consult with and provide information and records to other health care and mental health providers, including school health professionals, and for purposes of program evaluation and quality assurance. I understand that health records are confidential and will not be open to the school personnel unless the parent/guardian gives written consent, or in the case of treatment for which the minor has the right to consent, unless the minor gives written consent. I have received a copy of the the provider notice of privacy. I understand that New Mexico law does not require parental consent for treatment or advice about sexually transmitted diseases, pregnancy or contraception to minors under 18 years of age and behavioral health counseling services to minors age 14 years or older.

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--I hereby acknowlede that I can view a copy of the Region 9 School Based Health Center's Notice of Privacy Practices at www.r9sbhc.org or request a copy at the clinic located on the campus of Ruidoso High School.

Signature of Parent/Guardian	**Date**
Signature of patient, if 18 years or older	Date

Revised 2023