Thundermist Health Center – West Warwick SBHC Patient Registration

SECTION A: PATIENT INFORMATION: Please complete for your child.

Patient Last Name_____ Patient First Name_____ Middle Initial_____

Preferred Name_____ Pronouns (she/her, he/him)_____

Address_____ Home Phone _____
(Street) (City/State) (Zip Code)

Cell Phone_____ Date of Birth _____Age_____ SSN#_____

Sex: Male ❍ Female ❍ Other ❍ Gender (all that apply): Boy ❍ Girl ❍ Transgender ❍ Other_____

Patient email:_____ Parent/Guardian email:_____

Besides a parent or guardian, who else may we contact in an emergency? _____
(Name) (Phone) (Relationship to patient)

Primary Care Provider's Name (regular doctor) _____ Primary Care Provider Phone Number_____

Pharmacy Name and Address_____ Regular Dentist's Name_____

Does your child have any allergies, including to latex? Yes ❍ No ❍ If yes, to what? _____

Is your child on any medication, including over the counter Yes ❍ No ❍ If yes, what kind and for what medical condition_____

_____

Does your child have any health problems or hospitalizations? Yes ❍ No ❍ If yes, what? _____

Has your child ever had a reaction to medication? Yes ❍ No ❍ If yes, what happened? _____

Please list any special needs your child has (physical, emotional, cultural, religious or learning styles/preferences)

_____

I have read the attached parent notification form and my child may receive the following services at the Health Hut and/or Thundermist Health Center:

(Please check each service)

Medical Services (as outlined in Health Hut Handbook)	Yes ❍	No ❍	
Nutritional Counseling	Yes ❍	No ❍	
Behavioral Health Services and Counseling	Yes ❍	No ❍	
Dental Services	Yes ❍	No ❍	If yes, date of last dental visit: _____

If you marked "Yes" to Dental previously, your child will automatically be scheduled to receive an examination, cleaning, fluoride treatment, X-rays, and sealants if required. You must fill out the following information if you want your child to receive dental services.

Asthma ❍ Seizure/Epilepsy ❍ Mental Health/Behavioral Issues ❍ Diabetes ❍ Bleeding Disorder ❍ Heart Valve Replacement ❍

SECTION B: FAMILY INFORMATION: Please complete below for the custodial parent/guardian

Parent/Guardian_____ SS# _____
(Last) (First) (Middle)

Address _____ Date of Birth _____
(Street) (City/Town) (State) (ZIP Code)

Primary Phone Work Phone Employer_____
(Name) (Address)

Over...

SECTION C: INSURANCE COVERAGE: if you have no medical/dental insurance, please write "none."

Please list ALL medical and dental insurance coverage for the patient including Medicaid, Medicare, Rite Care, and private insurance.

1. Name of Insurance_____ Policy/ID Number _____

Whose name is the insurance in? _____ the patient _____the parent or spouse in Section B above

_____Other: Name_____ Date of Birth _____ SS# _____

Relationship to Patient_____

2. Name of Insurance _____ Policy/ID Number _____

Whose name is the insurance in? _____ the patient _____the parent or spouse in Section B above

_____Other: Name_____ Date of Birth_____ SS# _____

Relationship to Patient_____

SECTION D: CONSENT AND SIGNATURE Please sign below. Parent/Guardian must sign for minor children.

ALL PATIENTS: This Section must be completely filled out for you/your child to receive services at the Health Hut and/or at Thundermist Health Center. I certify that I am presenting myself/my child for services provided by Thundermist. I give Thundermist and its staff my permission to: (a) use any information contained in my (my child's) records in order to process requests for payment from my medical or dental insurance company; and (b) disclose any information contained in my (my child's) records to representatives from the West Warwick Education Department for the purposes of scheduling services or coordinating care. I also give the West Warwick Education Department permission to share my/my child's relevant information with Thundermist. Thundermist will maintain strict confidentiality with regards to all information about me/my child, according to all applicable State and Federal laws, and Thundermist policies. I understand that my/my child's medical records are the property of Thundermist and will not be released without my express written consent except in those circumstances permitted by law or to the West Warwick Education Department as provided above. I have received a copy of the Health Hut Patient Handbook which includes Patient Rights and Responsibilities. I understand that I may ask staff for assistance if I have any questions about these policies. I understand that a copy of a visit note will be provided to my/my child's primary care provider when seen for medical services and may be provided to my/my child's dentist when seen for dental services. I hereby acknowledge that I have received a copy of Thundermist Health Center's Notice of Privacy Practices. I authorize Thundermist staff to provide me (my child) reasonable and proper care by today's standards. A copy of the signature below is as valid as the original and remains in effect until my child is no longer enrolled as a student in the West Warwick school system.

x Signature of Parent/Guardian/Student if 18 or Older _____ Date _____

Scan to view the
Health Hut Handbook.