PATIENT INFORMATION-SCHOOL

SFSD Only:
Classroom#: __________
IC Medical flag: ________
IC Dental flag: _________

Would you like your child seen at the School Clinic?

DENTAL ☐ Yes ☐ No MEDICAL ☐ Yes ☐ No

Child's Name: ______________________________ Grade: __________
Last First Middle Initial

Address: ____
Street Apt. No. City State Zip

Phone Number: ______________ (Home) ______________ (Cell) Email Address: ________________

Date of Birth: ______________ Gender: ☐ Male ☐ Female Social Security Number: ______________

Parent or Authorized Person of Child:

____
Last First Middle Initial Date of Birth Social Security #

Emergency Contact Name: ______________________ Contact Phone Number: ______________

Do you speak English? ☐ Yes ☐ No If **No**, what language do you speak? ______________

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other (please specify): ☐ White (not Hispanic or Latino)

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Where would you like your prescriptions called to? ______________________________

List any medical or behavioral problems: ______________________________

List any medications: ______________________ List any allergies: ______________________

Medicaid/Insurance ☐ Yes ☐ No Policy No.: ______________ Group No.: ______________

Insurance Name: ______________ Policy Holder Name: ______________ Date of Birth: __________

Dental Insurance ☐ Yes ☐ No Policy No.: ______________ Group No.: ______________

Policy Holder Name: ______________ Date of Birth: ______________

Do you have a permanent home (house, apartment, etc.)? ☐ Yes ☐ No

Please complete for all people in your home:

Last name, First name	Relationship to Responsible Party	Date of Birth	Name of Health Insurance Company	Employer Name	Patient at Clinic
		/ /			Y or N
		/ /			Y or N
		/ /			Y or N
		/ /			Y or N
		/ /			Y or N

You may be eligible for a discount on services based on your household income. Please contact the front desk or Billing Office for more information.

Sign back of form

C:\Users\c9188\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\AZ9TW6WH\21-22 HAWTHORNE English.docx

Statement of Financial Responsibility and Assignment of Payer Benefits

I agree that I am financially responsible for all charges related to services provided by Falls Community Health (FCH). I agree FCH will bill and provide necessary health information to any Payers. “Payers” are any health care insurance, private or government health plan, or insurance policy that I have or another third party that will pay the charges I have incurred. My signature on this form is my authorized signature for the filing of a claim and request for direct payment or benefits by any Payer to FCH. I agree that unless FCH have agreed with the Payer to accept payment from the Payer as full payment, I am responsible to pay any charges not paid by the Payer. These charges can include but are not limited to co-pays, deductibles, co-insurance amounts and charges for non-covered services.

Consent to Treatment-Sharing of Information from FCH

I consent to exams, treatments, diagnostic tests, and medications that any provider at FCH feels is necessary for the health of my child.

I acknowledge that no guarantees have been made to me and I am aware that I have the right to ask my provider or nurse questions regarding my child’s treatment or exam.

I consent to my child receiving healthcare services via telehealth when an in person clinical provider is not available. Details of your child’s medical history, examinations, x-rays, and tests will be discussed with interactive video, audio and telecommunications technology. Physical examination of your child may take place and non-medical personnel may be present in the telehealth visit to aid in video transmission. Video, audio, and/or digital photos may be recorded during the telehealth consultation visit.

I authorize FCH to disclose my child’s confidential information only for treatment, payments, or health care operations. FCH may share clinical information with the Sioux Falls School District to coordinate care.

I give consent to nursing assessment, health supervision, immunizations, and release of information as indicated to the Sioux Falls School District.

Consent to Obtain External Prescription History

I consent to provide FCH access and use of my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes. I understand that my prescription history from other medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions dating back for several years. I acknowledge that FCH may use health information exchange systems to electronically transmit, receive and/or access my prescription history.

Notice of Privacy Practices and Sharing of Information from School District

I have been offered a copy of this office’s Notice of Privacy Practice. We reserve the right to change this Notice. A posted copy of the current Notice is in our facility and on our website www.siouxfalls.org/fch. The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of students’ personal information held by educational agencies or institutions. I give the Sioux Falls School District permission to share personally identifiable student information with Falls Community Health. This information will only be used to coordinate care with FCH. The information shared will be limited to demographic, insurance status, and health history.

Acknowledgement & Authorization

I have read the information above, and have had the opportunity to ask questions and have them answered to my satisfaction. If I am not the patient identified on the form, I represent that I am authorized by law to agree to these conditions on the patient’s behalf and am the authorized representative of the patient.

______________________________	______________________________	______________
Signature of Parent or Authorized Person	Print Name/Relationship	Date

FOR OFFICE USE ONLY

Entered into Playground ________________ **Entered into eCW** ________________ **Entered into Dentrix** ________________