



**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: \_\_\_\_\_

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Please mark any of the following conditions or health concerns and describe any marked:

- \_\_\_\_\_ Asthma Date of last asthma attack: \_\_\_\_\_
- \_\_\_\_\_ Seizures Date of last seizure: \_\_\_\_\_
- \_\_\_\_\_ Hearing Problems \_\_\_\_\_
- \_\_\_\_\_ Vision Problems \_\_\_\_\_
- \_\_\_\_\_ Sickle Cell Anemia \_\_\_\_\_
- \_\_\_\_\_ Heart Problems(explain) \_\_\_\_\_
- \_\_\_\_\_ Bleeding Disorders (explain) \_\_\_\_\_
- \_\_\_\_\_ Orthopedic (bone or joint) problems \_\_\_\_\_
- \_\_\_\_\_ Anxiety/Depression \_\_\_\_\_
- \_\_\_\_\_ Surgeries/Hospitalizations (list with dates) \_\_\_\_\_
- \_\_\_\_\_ Others \_\_\_\_\_
- \_\_\_\_\_ Family History (list condition and relationship) \_\_\_\_\_

Does the patient use tobacco? _____ what kind: _____ how much: _____
Does the patient drink 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](http://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.**