## PATIENT REGISTRATION AND HISTORY FORM

PATIENT NAME_____D.O.B_____SEX____RACE_____

**ILLNESS HISTORY (BEFORE FIRST VISIT)** _____Good _____Fair _____Poor

General History of: _____ADD/ADHD _____Diabetes _____Pneumonia
_____Allergies _____Ear Infections _____Pregnancy
_____Asthma _____Heart Problems _____UTI's/Testing
_____Chicken Pox _____High Blood Pressure

Major Illnesses: _____

Hospital Stays: _____

Operations: _____

Disabilities/Limitations: _____

SOCIAL HISTORY

Lives with: _____

Does patient smoke: _____

Does family member/caregiver smoke: _____

DENTAL HISTORY

Dentist Name: _____DDS None: _____

Dental Problems: _____

Last Time Seen by a Dentist: _____

**Who do we have permission to contact in case of an emergency and/or in the event that a medical message must be given to the students' parents or legal guardians when the parent or legal guardian cannot be reached by phone.**

**NAME:** _____**RELATIONSHIP** _____**PHONE** _____
**NAME:** _____**RELATIONSHIP** _____**PHONE** _____
**NAME:** _____**RELATIONSHIP** _____**PHONE** _____

If you have any questions while completing the remainder of this form, please contact us. Please notify School-Based Health Center of any changes to the information on this form.

**ASSIGNMENT AND RELEASE:** I hereby authorize my insurance benefits to be paid directly to St. Luke Hospital. I acknowledge that I am responsible for payment for all services rendered to _____(child's name), whether or not these services are paid by said insurance. I hereby authorize St. Luke Hospital to release any information necessary to secure payment. This assignment and release will remain in effect until revoked by me in writing. A photocopy of this assignment and release is considered to be valid as the original.

If at any time I do not have health insurance coverage, I will notify St. Luke Hospital Credit at 572-3624, so that an agreement can be reached for payment of lab fees rendered to child/dependent named above.

SIGNATURE _____DATE SIGNED _____

(This form developed by Newport School Based Health Center)

**Formatted:** Space Before: 2 pt, After: 0 pt

**Formatted:** Space Before: 2 pt

**Formatted:** Space Before: 2 pt, After: 0 pt

**Formatted:** Normal, Left, Space Before: 2 pt