Orchard School Clinic
Patient Information Form

STUDENT INFORMATION

Student's Last Name: _____

Student's First Name: _____

Date of Birth: _____/_____/_____
Month Day Year

Sex: ❑ Male ❑ Female Grade _____

Ethnicity: ❑ Hispanic ❑ Black ❑ White ❑ American Indian
❑ Asian/Pacific Islander ❑ Other _____

Student Address:_____

_____

_____ _____ _____
City State Zip Code

Does the student communicate in a language other than English?
❑ No ❑ Yes: Language _____

Who is the student's regular doctor?

Name: _____

Telephone: _____

Address: _____

_____

PARENT/GUARDIAN INFORMATION

Mother

Last Name: _____First Name: _____

Cell Phone # _____

Father

Last Name: _____ First Name: _____

Cell Phone # _____

Legal Guardian, If Applicable

Last Name: _____First Name: _____

Relationship of legal guardian to student
❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Contact Information for parent or guardian

Home Tel: _____Work Tel: _____

Cell: _____

Additional Emergency Contact

Name: _____

Relationship to Student: _____

Home Tel: _____ Work Tel: _____

Cell: _____

INSURANCE INFORMATION

Does your child have Medicaid or HMK/CHIP?

❑ No ❑ Yes: Medicaid ID # _____

Does your child have coverage through your employer or any other type of health insurance?

❑ No ❑ Yes, Health Plan: _____

Member ID/Policy Number: _____

Health Insurance Phone: _____

If your child does not have health insurance, would you like a Certified Application Counselor to contact you to enroll into health insurance?

❑ No ❑ Yes

PREFERENCES

Does your child have a regular dentist?

❑ No ❑ Yes: Name_____

Preferred Pharmacy:

Name:_____

Location:_____

Do you wish to apply for our sliding fee scale which is based on income and family size? ❑ No ❑ Yes