

# Orchard School Clinic Patient Information Form

STUDENT INFORMATION	PARENT/GUARDIAN INFORMATION
<p><b>Student's Last Name:</b> _____</p> <p><b>Student's First Name:</b> _____</p> <p><b>Date of Birth:</b>      _____ / _____ / _____  <span style="margin-left: 100px;"><i>Month</i></span>      <span style="margin-left: 100px;"><i>Day</i></span>      <span style="margin-left: 100px;"><i>Year</i></span></p> <p><b>Sex:</b>    <input type="checkbox"/> Male    <input type="checkbox"/> Female      <b>Grade</b> _____</p> <p><b>Ethnicity:</b>   <input type="checkbox"/> Hispanic   <input type="checkbox"/> Black   <input type="checkbox"/> White   <input type="checkbox"/> American Indian  <input type="checkbox"/> Asian/Pacific Islander   <input type="checkbox"/> Other _____</p> <p><b>Student Address:</b> _____  _____  _____</p> <p style="text-align: center;"><i>City</i>                      <i>State</i>                      <i>Zip Code</i></p> <p><b>Does the student communicate in a language other than English?</b>  <input type="checkbox"/> No   <input type="checkbox"/> Yes: Language _____</p> <p><b>Who is the student's regular doctor?</b></p> <p>Name: _____</p> <p>Telephone: _____</p> <p>Address: _____  _____</p>	<p><b><u>Mother</u></b></p> <p>Last Name: _____ First Name: _____</p> <p>Cell Phone # _____</p> <p><b><u>Father</u></b></p> <p>Last Name: _____ First Name: _____</p> <p>Cell Phone # _____</p> <p><b><u>Legal Guardian, If Applicable</u></b></p> <p>Last Name: _____ First Name: _____</p> <p>Relationship of legal guardian to student  <input type="checkbox"/> Grandparent   <input type="checkbox"/> Aunt or Uncle   <input type="checkbox"/> Other: _____</p> <p><b><u>Contact Information for parent or guardian</u></b></p> <p>Home Tel: _____ Work Tel: _____</p> <p>Cell: _____</p> <p><b><u>Additional Emergency Contact</u></b></p> <p>Name: _____</p> <p>Relationship to Student: _____</p> <p>Home Tel: _____ Work Tel: _____</p> <p>Cell: _____</p>
INSURANCE INFORMATION	PREFERENCES
<p><b>Does your child have Medicaid or HMK/CHIP?</b>  <input type="checkbox"/> No   <input type="checkbox"/> Yes: Medicaid ID # _____</p> <p><b>Does your child have coverage through your employer or any other type of health insurance?</b>  <input type="checkbox"/> No   <input type="checkbox"/> Yes, Health Plan: _____</p> <p>Member ID/Policy Number: _____</p> <p>Health Insurance Phone: _____</p> <p><b>If your child does not have health insurance, would you like a Certified Application Counselor to contact you to enroll into health insurance?</b>  <input type="checkbox"/> No   <input type="checkbox"/> Yes</p>	<p><b>Does your child have a regular dentist?</b>  <input type="checkbox"/> No   <input type="checkbox"/> Yes: Name _____</p> <p><b>Preferred Pharmacy:</b></p> <p>Name: _____</p> <p>Location: _____</p> <p><b>Do you wish to apply for our sliding fee scale which is based on income and family size?</b>    <input type="checkbox"/> No    <input type="checkbox"/> Yes</p>