Tensas
SCHOOL-BASED HEALTH CENTER

NEW PATIENT PAPERWORK

PATIENT INFORMATION **Today's date:**

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name: *First* *MI* *Last*

Mailing Address: *City* *State* *ZIP*

Physical Address: *City* *State* *ZIP*

SS#: Birthdate:

Home #: Work #: Cell#:

Primary Care Physician *(Shown on Insurance Card):*

School: Grade:

Student Email: Student Cell Phone #:

Primary Care Physician *(Shown on Insurance Card):* Phone:

Dentist: Phone:

Names of siblings enrolled in Tensas School-Based Health Center:

Birth Sex ☐Male ☐Female

Sexual Orientation
☐ Straight *(not lesbian or gay)* ☐ Lesbian or Gay
☐ Bisexual ☐ Other ☐ Don't know
☐ Prefer not to disclose

Gender Identity
☐ Male ☐ Female
☐ Transgender Male *(female to male)*
☐ Transgender Female *(male to female)*
☐ Genderqueer *(neither exclusively male or female)*
☐ Other ☐ Don't know ☐ Prefer not to disclose

Race*(check one)* ☐ Asian ☐ Native American ☐ Pacific Islander ☐ Caucasian ☐ Black/African American
☐ American Indian/Alaska Native ☐ More than one race ☐ Prefer not to disclose

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Are you a Veteran ☐No ☐Yes

Housing Status ☐ Rent/Own ☐ Transitional ☐ Homeless ☐ Street ☐ Doubling Up ☐ N/A

Agricultural Status ☐ Migrant Worker ☐ Seasonal Worker ☐ Dependent of Migrant
☐ Dependent of Seasonal ☐N/A

Annual Household Income ☐Less than $10,000 ☐$10,001-$20,000 ☐$20,001-$40,000
☐$40,001-$60,000 ☐$60,001-$100,000 ☐$100,000+ ☐Prefer not to disclose

Number of people living in your household: _____

RESPONSIBLE PARTY

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name: *First* *MI* *Last*

Home #: Work #: Cell#:

Billing Address:

SS#: Birthdate: ☐ Male ☐ Female Relation:

EMERGENCY CONTACT *(Neighbor or Relative not living with you)*

His/Her Name: Relation:

Home #: Work #: Cell#:

INSURANCE INFORMATION *(Please check the type of health insurance:)*

☐ **Medicaid/Healthy Louisiana Plan** *(formerly Bayou Health)* #:

☐ Healthy Blue ☐ AmeriHealth Caritas LA ☐ Aetna Better Health LA

☐ LA Healthcare Connections ☐ United Healthcare Community Plan LA

Medicaid (dental) #:

☐ **Medicare #:**

☐ **No Insurance**

☐ **Private/Other Insurance Name**_____

Employer/ Address:_____Phone #:_____

Policy #:_____ Group #:_____Effective Date:_____

Name of policy holder:_____ Relation:_____

Policy holder date of birth:_____ Policy holder Social Security #:_____

Does your insurance pay for prescriptions? ☐ No ☐ Yes Dental Coverage? ☐ No ☐ Yes

☐ **Secondary Insurance Name**_____

Employer/ Address:_____Phone #:_____

Policy #:_____ Group #:_____Effective Date:_____

Name of policy holder:_____ Relation:_____

Policy holder date of birth:_____ Policy holder Social Security #:_____

Does your insurance pay for prescriptions? ☐ No ☐ Yes Dental Coverage? ☐ No ☐ Yes

GENERAL INFORMATION

Pharmacy Name: Phone:

Do you have reliable transportation? ☐ No ☐ Yes Do you have prescription drug coverage? ☐ No ☐ Yes

Do you currently qualify for any government programs? (*such as Medicaid, WIC, welfare, food stamps, Social Security disability or unemployment)* ☐ No ☐ Yes , Please list:

If you do not currently have Medicaid, have you ever applied for Medicaid? ☐ No ☐ Yes

What was the outcome?

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PATIENT PAPERWORK CONTINUED

STUDENT'S NAME _____ 2ND IDENTIFIER _____

MEDICAL AND HOSPITALIZATION INFORMATION:

Is your child allergic to any food? Medicine? Insect? Latex? Other? ☐ No ☐ Yes

If yes, list:_____

List of current medications student is on with dosage (how much) and how often:

_____

_____

Has your child been admitted into a hospital or had surgery: ☐ No ☐ Yes If Yes, Year: _____

Reason: _____ Hospital:_____

Date of last comprehensive physical/well check____/____/____

Performed by PCP_____ or Someone else_____

PLEASE MARK THE ITEM(S) THAT APPLY TO YOUR CHILD'S MEDICAL HISTORY:

☐ Asthma ☐ Behavior Problems ☐ Endocrine *(Diabetes, Thyroid, Pituitary)*

☐ Allergy ☐ Depression ☐ Infectious Disease *(Hepatitis, HIV, TB, Meningitis)*

☐ Tonsillitis ☐ Substance Abuse ☐ Missing Organ *(Kidney, Eyes, Testicles)*

☐ Seizures ☐ Anxiety ☐ Blood Disorder

☐ Kidney Disease ☐ ADHD ☐ Birth Defects - Genetic Disorder

☐ Skin Problems ☐ Heart Disease/Murmur Reasons ☐ Vision Problems

☐ Chicken Pox ☐ Ear or Sinus infections ☐ Been Restricted from Sports/PE

☐ Major Injuries ☐ Hearing & Speech Problems ☐ Other (specify) _____

Please describe any item marked: _____

_____

FAMILY HISTORY:

Please mark the item(s) that apply to your family's history: *(B=brothers, S= sisters, P= parents and G=grandparents)*

☐ Cancer ☐ Depression ☐ Genetic Disorder ☐ Stroke

☐ Asthma ☐ Substance Abuse ☐ Sickle Cell ☐ Tuberculosis

☐ Seizures ☐ Anxiety ☐ Heart Disease/Heart Problem

☐ Allergy ☐ ADHD ☐ High Blood Pressure

☐ Anemia ☐ Diabetes ☐ Other (specify) _____

Please describe any item marked (Who/When): _____

_____

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PATIENT CONSENT

ALL SERVICES ARE PROVIDED BY LICENSED PROFESSIONALS

By signing this consent, you are agreeing to allow the School-Based Health Center to provide the following services to your child:

- Primary And Preventive Health Care
- Comprehensive History And Physical Examinations
- Immunizations
- Health Screenings
- Laboratory/Diagnostic Testing
  (Including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law)
- Management Of Chronic Diseases
- Acute Care For Minor Illness And Injury Including Medications, If Indicated
- Behavioral Health Services
- Referral And Follow-Up For Emergencies
- Case Management
- Referral To Specialty Care
- Health Education And Prevention Programs
- Dental Services (Provided By Tensas Dental Clinic)

MEDICATION CONSENT:

Tensas School-Based Health Center will administer medications with the NP and/or Doctor's orders. Over-the- Counter medications may be administered such as Pain Relievers, Cold Medications, Ear Drops, Eye Drops, Stomach Medication (Pepto-Bismol, Mylanta, Midol), Wound Medications, Anti-Itch Medication, and other topical cream/gels for other complaints, such as Orajel, Carmex, or Vaseline. Prescription medication may be given if found necessary after examination as well. Antibiotic injections such as Rocephin may be given if deemed necessary by the NP or MD. Nebulizer medications may be administered for asthma type symptoms, if necessary, for treatment of students. Age appropriate Immunizations will be given to bring the student up to date according to the CDC guidelines, if the student is not up to date at the time of the exam.

I understand this student may receive all medications offered at the School-Based Health Center except those which I have written here:_____

IMMUNIZATION CONSENT:

Age appropriate immunizations, including the Flu and HPV vaccines, **will be given** to bring the student up to date according to the CDC guidelines, if the student it not up to date at the time of the exam.

I understand my student may receive all immunizations offered at the School-Based Health Center except those which I have written here or checked below: _____

I DO NOT WANT CHILD TO HAVE: ***(please check below if you do not want your child to receive either the flu or HPV vaccine):***

☐ **FLU VACCINE** – Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact. Anyone can get the flu, but the risk of getting flu is highest among children. Each year thoughts of people in the United State die from flu, and many more are hospitalized, This vaccine will help prevent contraction of the flu virus.

☐ **HPV VACCINE-** This vaccine is recommended for males and females ages 11-26 years of age. HPV is the most common sexually transmitted virus in the United States. This vaccine can prevent most cases of cervical cancer in females, if it is given before exposure to the virus. In addition, if can prevent vaginal and vulvar cancer in females, and genital warts and anal cancer in both male and females.

TELEMEDICINE:

I hereby authorize the use of telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical care. I understand the rationale for using telemedicine in place of in-person services, as well as the risks and benefits of the utilization of telemedicine, including privacy related risks, and acknowledge that all electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws. I acknowledge that I have had the opportunity to ask my questions regarding the use of telemedicine and the risks and benefits of alternative methods, including the risks and benefits of no treatment.

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GENERAL CONSENT

CONFIDENTIALITY:

The School-Based Health Centers (SBHCs) adhere to all current laws regarding confidentiality of health services in general and specifically as they relate to services to minors. All medical and mental health records are confidential and will be maintained as directed by the Health Insurance Portability and Accountability Act (HIPAA). I consent to the exchange of relevant health information between Tensas School-Based Health Center and the student's personal medical provider upon referral for medical care. I have been given a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Tensas Parish School-Based Health Center has the right to change this notice at any time. I may obtain a current copy by contacting the School-Based Health Center or their website. My signature on this consent constitutes my acknowledgment that I have been provided a copy of the Notice of Privacy Practices.

LAHIE STATEMENT:

We understand that the SBHC may participate in one or more health information exchanges (HIEs), whereby the center may share/receive my health information with other health care providers for treatment, payment or health care operations purposes. We hereby consent to the disclosure of the SBHC's records into the HIEs.

I, as parent/guardian, understand that I will not be charged for any of the services provided at the School-Based Health Center. I also understand that Tensas Community Health Center or the medical provider may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directed to Tensas Community Health Center,

By signing below, we (student and parent/guardian) acknowledge that we have read and understand the services to be provided at the School-Based Health Center. We both give permission for this student to receive the services provided by the program.

This consent is effective while the student is enrolled in any school within Tensas Parish unless the School-Based Health Center is notified in writing, that I no longer wish for my child to receive services. That form may be obtained from my nearest health center. I also understand that I may be asked update important information every year.

We also understand Tensas School-Based Health Center is operated by Tensas Community Health Center and its employees and contractors.

Printed Name of Parent/Legal Guardian/Student	Relationship
Signature of Parent/Legal Guardian	Date
Signature of Student (optional)	Date

This consent may be withdrawn or modified at any time with written permission of the parent/guardian and student to the entity referred to above. A duplicate copy of this document will be given to parents or guardians upon request.

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TRANSPORTATION CONSENT

STUDENT'S NAME _____ **DATE OF BIRTH** _____

I consent to my child being transported by van or shuttle bus by TCHC from my child's school to Tensas School-Based Health Center or TCHC or Tensas Dental if necessary. I understand that the Tensas Parish School Board has no involvement in transporting my child and that no one from the School Board will accompany my child while riding in the TCHC's van/bus. I acknowledge, that during transportation, my child will be under the sole supervision of TCHC. I release the School Board from any damages of injuries my child may sustain while being transported by TCHC.

_____
Printed Name of Child

_____
Printed name of Parent/Legal Guardian

_____
Child's Date of Birth

_____
Parent/Legal Guardian Signature

_____
Phone Number

_____
Date

TENSAS SCHOOL-BASED HEALTH CENTER

916 Plank Road *Saint Joseph, LA 71366* *Phone: (318) 766-1080*

Tensas
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DENTAL CONSENT

STUDENT NAME:_____ **STUDENT DATE OF BIRTH:**_____

Does your Student have a dentist he/she sees routinely? ☐ No ☐ Yes - Dentist's Name:_____

When did your student last have their teeth cleaned? ☐ Not Sure ☐ 6 months ago ☐ 12 months Ago

When did your student last have dental X-rays taken? _____

How often does your student eat sweets, Mints, or chews sugar gum? List Type:
☐ Everyday ☐ Once/week ☐ Once/Month ☐ Hardly Ever

How often/when does your student drink soda or other sweet drinks?_____

Is your student having medical or dental problems, pain or discomfort at this time? ☐ No ☐ Yes
If so, please describe: _____

Has your student ever experience any complications of any kind during dental treatment? ☐ No ☐ Yes
If yes please explain: _____

Is your student allergic to latex? ☐ No ☐ Yes ☐ I don't know

I consent for my child to receive the following dental services from Tensas Dental Clinic:

DENTAL CLEANING- Dental cleanings involve removing plaque (soft, sticky film) and tartar that has built up on the teeth over time, polishing the teeth, x-rays, fluoride treatment.

CAVITY FILLINGS- The dentist will remove the cavity (decayed portion of the tooth) and then "fill" the area on the tooth where the cavity was removed. The filling material can be either white (composite) or silver (amalgam). Most cavity fillings require the tooth to be numbed.

SEALANTS- Protectant material that coats the chewing surface of the bath teeth to prevent cavities.

Potential complications from these procedures include, but are not limited to, sensitivity, swelling and bleeding of the gums. **Any additional dental services will have a separate consent to be signed at the time the services are provided.** The patient's medical history will be updated at every visit. If your student has a dentist that he/she sees on a regular basis, we encourage you to continue to seek care through that provider. The parent/guardian may be present for all dental visits. If you wish to be present when dental services are provided, you must contact the clinic noted below. **I, a parent/guardian understand that I will not be charged for any of the services provided through Tensas Dental Clinic.** I also understand TCHC or the dentist may bill Medicaid or other insurance providers for these services. I authorize/assign payments of authorized benefits directed to Tensas Community Health Center. I understand that the dental services billed to the student's insurance company may be counted towards any annual benefit limitations. I attest that I am the parent or legal guardian of this student and have legal authority to sign this consent form.

_____ _____
Printed Name of Parent/Legal Guardian/Student Relationship

_____ _____
Signature of Parent/Legal Guardian Date

TENSAS DENTAL CLINIC
406 Levee Street *Saint Joseph, LA 71366* *Phone: (318) 766- 9115*

Tensas
SCHOOL-BASED HEALTH CENTER

MEDICAL RELEASE FORM

As required by the Health Insurance Portability and Accountability Act (HIPPA) of 1996, TVCHC may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the use and disclosure of protected health information described herein.

I, _____understand that the information contained in my

record is confidential. However, I give consent of _____

At _____to release all of my records or information

concerning such records to **Tensas School-Based Health Center.**

I understand that the document authorized to be released by me include, but are not limited to, family histories, reports of clinic findings and diagnosis, laboratory test, X-rays, reports of examination and/or evaluation, and any hospital admission or discharge records.

I understand that I may revoke this consent at any time except to the extent that action has been taken thereon. I further understand that this consent will expire upon_____(not to exceed six months) and cannot be renewed without my written consent.

Signature_____

Signature of Witness_____

PATIENT IDENTIFYING DATA

Name: First_____MI_____Last_____

Address:_____City_____State_____ZIP_____

SS#:_____Birthdate:_____

TENSAS SCHOOL-BASED HEALTH CENTER

916 Plank Road Saint Joseph, LA 71366 Phone: (318) 766-1080

Tensas
SCHOOL-BASED HEALTH CENTER

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please return this form to Dawn Johnson, Privacy Officer at 402 Levee Street Saint Joseph, LA 71366 acknowledging your receipt and review of Tensas Community Health Center, Inc.'s Notice of Privacy Practices.

Name: _____

Signature: _____

Relationship if not Patient:_____ Date:_____

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Tensas
SCHOOL-BASED HEALTH CENTER

To the Parent/Guardian of: _____

Our records indicate that your child may be due for one or more immunization(s). If your child has received these immunizations by another health care provider, please notify us so that the child's immunization record may be updated.

The following immunizations are required for school attendance:

To avoid delayed entry to school this upcoming year, please contact Tensas School-Based Health Center, Tensas Community Health Center at (318) 766-1967, or your child's primary care provider, to schedule an appointment to have your child vaccinated.

We look forward to hearing from you.

Thank you,

Edwina Eley, APRN, FNP-C

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