Outpatient Medical Center
Providing Quality Healthcare To All.

ENROLLMENT FORM SCHOOL-BASED HEALTH CENTER

Student's Name: Last First Middle Initial				ID#(Office use only)
Student's Address (include city):				Zip Code:
Student's Date of Birth:	Age:	Sex:[]Male []Female	Ethnicity: [] Hispanic/Latino []Not Hispanic/Latino	
Race: []American Indian or Alaska Native []Asian []Black or African American []White []Native Hawaiian or Other Pacific Islander []More than one race				
Student's Social Security Number	School and Grade:			
Preferred Language:	Parent/Guardian/Student Email:		Student Cell Phone #:	
Name of Mother or Legal Guardian:	Home Phone:	Work Phone:	Cell Phone:	Employer:
Name of Father or Legal Guardian:	Home Phone:	Work Phone:	Cell Phone:	Employer:
Emergency Contact:		Relationship:		Phone:
Emergency Contact:		Relationship:		Phone:
Name of Students Primary Care Physician: []Please check if student does not have a Primary Care Provider				Phone:
Preferred Pharmacy: (Name and location)		Names of siblings enrolled in School-Based Health Center:		

Please check the type of health insurance your child has: Please send a copy of insurance card (front and back) to SBHC.	a Medicaid/Healthy Louisiana#:_____(check one below) []Aetna Better Health []Healthy Blue []AmeriHealth Caritas LA []LA Healthcare Connections []United HealthCare Community Plan []No insurance [] Private/Other Insurance Co. Name: _____ Co. Address:_____ Phone #:_____Policy #:_____ Group#:_____ Effective Date:_____ Name of policy holder:_____ Relationship to student:_____ Policy holder date of birth:_____ Policy holder Social Security #:_____ Policy holder employer: _____ Does your insurance pay for prescriptions? [] No [] Yes

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AUTHORIZATION FOR TREATMENT

The UNDERSIGNED gives authorization for treatment considered necessary for the patient whose name appears below by the Centers Provider.
The UNDERSIGNED has read and fully understands the statement above, Further, the UNDERSIGNED understands that no guarantee or assurance has been made as to the results that may be obtained.
This AUTHORIZATION wilt be effective from the date of signature unless withdrawn by the patient or authorized person.

AUTHORIZATION FOR PAYMENT

The UNDERSIGNED authorizes the release of medical information necessary to process claims. Further, the UNDERSIGNED authorizes payment of medical and/or dental benefits to the assigned physician.

I give permission for my child to be photographed for the health center electronic medical records system. Yes_____ No_____

Do you authorize OMC Inc. to vaccinate your child? Yes____ No____
Has your child ever had a reaction to a vaccine? Yes____ No____
*If so, what was the reaction and what was the vaccine?

_____
_____

About our NOTICE OF PRIVACY PRACTICES

The Board of Directors, Administration, and Staff at Outpatient Medical Centers, Inc. is committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligations under the law with respect to your personal health information.
- How we may be used and disclose the health information that we keep about you.
- Your rights relating to your personal health information.
- Our rights to change our Notice of Privacy Practices.
- How to file a complaint if you believe your privacy rights have been violated,
- The Conditions that apply to uses and disclosures not described in this Notice. ♦ The persons to contact for further information about our Privacy Practices.

Outpatient Medical Centers, Inc. is required by law to give you a copy of (his notice and to obtain your written acknowledgement that you have received a copy of this notice.

_____ _____
Patient's Full Name Date

_____ _____
Patient/Parent/Guardian Signature Relationship

Please select treatment wanted:

[ ] Medical treatment [ ] Dental Treatment