

FOR OFFICE ONLY:

Acct # _____	Initial _____	Date _____
--------------	---------------	------------

PUGET SOUND NEIGHBORHOOD HEALTH CENTERS
School-Based Health Center Program

Student Registration Form

Please help us serve you better and comply with our reporting requirements by providing the following confidential information.

Print Student's Name _____ Female Male
(Last) (First) (Middle)

Address _____ Home phone _____
Street _____ City _____ State _____ Zip _____

SS# _____ Birth Date _____ Student ID _____ Grade _____

Parent/Guardian _____ Home Phone _____ Relationship _____
Message Phone _____

Emergency Contact _____ Phone _____ Relationship _____

Insurance Information Completion of the insurance information below is required.

Does the student have health insurance? Yes No

If yes, which Plan Type: Private/Commercial Medicaid/Healthy Options Basic Health Plan

Insurance Company and Plan Name _____ Group Or Medicaid Number _____

Insurance Company Address _____ Phone _____

Policy Holder's Name _____ Birth Date _____ SS# _____

If no, are you interested in learning more about health insurance? Yes No

Race

Which of the following best describes the student's race? (Please check only one)

<input type="checkbox"/> African American/African Native	<input type="checkbox"/> Caucasian/White	<input type="checkbox"/> Pacific Islander—Native Hawaiian
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Pacific Islander--Other
<input type="checkbox"/> Asian	<input type="checkbox"/> Multi-Racial	<input type="checkbox"/> Other

Other Information

- Does the student live in public housing? Yes No
- Is the student homeless? Yes No If yes, what is the living arrangement?
 Doubling up Transitional Shelter Street Other
- Is the student or any member of the family a migrant or seasonal farm worker? Yes No
- Does the student have an ongoing disability that would stop her/him from doing daily activities? Yes No
- Is the student an immigrant or refugee or new arrival in this country? Yes No
- What is the number of family members reported on the federal income tax return? _____
- What is the number of family members under age 18, including the student? _____
- Does the student live in a single parent, non-partnered household? Yes No
- What primary language is spoken at home? _____

Does the student have a doctor (or a clinic)? Yes No If yes, please provide name and phone number

I certify that the information reported above is correct. I hereby authorize Puget Sound Neighborhood Health Centers (PSNHC) to bill my insurance company for any services provided by PSNHC. I authorize PSNHC to release to my insurance company or Center for Medicare and Medicaid Services any information needed to determine the benefits payable to related services.

Signature _____

Date _____

Relationship to Student _____

PLEASE CONTINUE TO NEXT PAGE ➔

