

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 →

