McIntosh County School
Telehealth

STUDENT INFORMATION PACKET

Date:______________Grade:___________Homeroom:__________________________School year:_________

Patient Information

Name: ____

Date of Birth_____________________________ Age_____________ Sex: M / F Race:______________

Street Address____

City:___________________________State:________Zip Code:_____________County: ___________________

Social Security Number:______________________________Primary Language:___________________________

Mother's/Guardian's Information

Name:____

Date of Birth:_________________Race:_____________Social Security Number:___________________________

Street Address:____

City:___________________________State:_________Zip Code:_____________County:_________________

Employer:____________________________________Work Number/Ext:_______________________________

Home Phone:_______________________Cell Phone:__Other:________________

Email Address: ____

Father's /Guardian's Information

Name:____

Date of Birth:_________________Race:_____________Social Security Number:___________________________

Street Address: ____

City:_________________________State:_________Zip Code:_____________County: ___________________

Employer:____________________________________Work Number/Ext: _____________________________

Home Phone:_______________________Cell Phone:____________________Other:______________________

Email Address: ____

Person to Notify in Case of Emergency (other than parent/guardian)

Name: _______________________________ Relationship to Patient:______________________________________

Street Address: ____

City:_________________________State:_________Zip Code: _____________

Home Phone:__________________Cell Phone:_________________________Other:_______________________

MEDICAL HISTORY

Name of Primary Care Physician______________________________

Address______________________________ Phone Number ______________

Name of Dentist______________________________

Address______________________________ Phone Number ______________

Name of any other Health Care Provider______________________________

Address______________________________ Phone Number ______________

Name of Pharmacy______________________________

Address______________________________ Phone Number______________

List Medication Allergies

1)______________________ **2)**______________________

3)______________________ **4)**______________________

List All Medical Problems (Ex: Asthma, ADD/ADHD, Autism, Hypertension, etc.)

1)______________ **2)**______________ **3)**______________

4)______________ **5)**______________ **6)**______________

List all Previous Surgeries

1)______________________ **2)**______________________

3)______________________ **4)**______________________

<u>Current Medication List</u> (Include dosage and time)

1)______________________ **2)**______________________

3)______________________ **4)**______________________

5)______________________ **6)**______________________

<u>Family History</u> (Ex: Hypertension, Cancer, etc.)

Mother______________________________

Father______________________________

Please list any religious/personal beliefs that may affect your care:

____

____

AUTHORIZATION TO BILL INSURANCE

Please note that McIntosh County School System is not responsible for billing or for the collection of any associated fees for the services provided. Your insurance will be billed by the physician's office, and you will be responsible for copays, deductibles, or any other charges not covered by your insurance.

Patient's Name____

Patient's Date of Birth__________________Patient's Social Security Number________________________

Primary Insurance Company

Insurance Company______________________________ Person Insured________________________

Insured's Date of Birth_______________ Insured's Social Security Number______________________

Policy or Member Number_________________________ Group Number__________________

Secondary Insurance Company (if applicable)

Insurance Company______________________________ Person Insured________________________

Insured's Date of Birth_______________ Insured's Social Security Number______________________

Policy or Member Number_________________________ Group Number__________________

Responsible Party

Name____

Date of Birth______________Employer __________________________

A COPY OF YOUR INSURANCE CARD IS REQUIRED

Information on this form is protected health information (PHI) and is to be treated as confidential under HIPPA rules, privacy & security. All services are charged directly to the patient or the patient's representative and/or insurance company by the provider. Acknowledgement: I consent to the use of PHI for purposes of treatment, payment and operations. I authorize the entity to use the PHI as needed. I authorize that payment of benefits be made on my behalf directly to the provider. I understand that I am financially responsible for all charges not covered by insurance.

Parent/Guardian Signature____**Date**______________________

HIPAA AND OUR PATIENTS

The HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule became law in 1996. The Office for Civil Rights enforces the HIPAA Privacy Rule, which protects the privacy of identifiable health information. This rule essentially controls the use and disclosure of what is known as Protected Health Information. We are required to provide you with the attached notice. We encourage you to read the information concerning our privacy practices. It is your copy to keep.

I acknowledge receipt of the HIPAA Notice of Privacy Practices from [*SBTC NAME HERE*].

Parent/Guardian Signature____**Date** ______________________