Jefferson County
General Health District
(740)283-8530
www.jchealth.com
Dr. Frank J. Petrola Health Commissioner

Public Health
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Medical Demographics Form

Patient Name:_____
Last name *First Name* *Middle Initial*

Address:_____
 # Street Name *City* *State* *Zip Code*

What school does your child attend:_____

Home phone :_____ Cell Phone:_____

Work phone:_____ E-Mail:_____

Preferred method of contact?_____

Gender:_____ Social Security number:_____/_____/_____

Date of Birth:_____/_____/_____ Race:_____

Ethnicity: Non-Hispanic or Hispanic (Circle one) Preferred Language:_____

Primary Care Provider:_____

Guardian Name(s) if patient is a minor:_____

Relationship to Patient: Parent Grandparent Foster Parent Other:_____

Primary Contact #:_____ Secondary contact:_____

Check all that applies to above: Emergency Contact ☐ Primary Care Giver ☐ Legal Guardian ☐

Lives with ☐

Name of Emergency Contact: (if different than above)_____

Primary Emergency Contact #: (if different than above)_____

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Medical Health History Form

Patient's name:_____ Date of birth:_____

Patient's family doctor:_____ Phone: (_____)_____-_____

Eye Glasses? ☐ No ☐ Yes Exposed to second hand smoke? ☐ No ☐ Yes

List Medications taken on a daily basis:

Name:_____ mg_____ Frequency_____
Name:_____ mg_____ Frequency_____
Name:_____ mg_____ Frequency_____

Please list any chronic health problems, previous hospitalizations, or surgeries:_____

Allergies (If yes, please list)

Food: ☐ No ☐ Yes If yes,_____
Medication: ☐ No ☐ Yes If yes,_____
Bees: ☐ No ☐ Yes If yes,_____

Any history of or difficulty with any of the following? (check if yes):

☐ AIDS/HIV	☐ Depression	☐ Mononucleosis
☐ Anemia	☐ Diabetes	☐ Mumps
☐ Asthma	☐ Drugs/Alcohol	☐ Pneumonia
☐ Bed Wetting	☐ Ear Infections	☐ Rheumatic Fever
☐ Birth Defects	☐ Epilepsy	☐ Sinus Problems
☐ Bladder Problems	☐ Fainting	☐ Speech Problems
☐ Bleeding. Excessive	☐ Hearing Problems	☐ Thyroid Problems
☐ Cancer	☐ Heart Problems	☐ Tuberculosis
☐ Cerebral Palsy	☐ Hepatitis	☐ Urinary Disease
☐ Chicken Pox	☐ Kidney Disease	☐ Vision Problems
☐ Constipation/Diarrhea	☐ Lead Poisoning	☐ Worms
☐ Convulsions	☐ Measles	☐ Other_____

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Date of last Well Child Visit:_____

The information that I have provided is accurate to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in patient's medical status.

Parent/Guardian's Signature:_____ Date:_____

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All Information is confidential

Date:_____ Patient's Full Name:_____
Date of Birth:_____ Social Security Number:_____
Grade:_____ Sex:_____ Race:_____

I authorize a physician, nurse practitioner, or designated health professional to provide necessary and/or advisable treatment for my child. I authorize release of written and verbal information relevant to my child's health care between the school nurse and the health center's staffs only when necessary for his/her care. In case of emergency, every effort will be made by the health center staff to notify the parent/guardian. I understand the acknowledgement of Notice of Privacy Practice and know my minor child's rights as a patient in the school-based health clinic. I authorize the school-based Health Clinic to release information regarding treatment to third party payer such as Medicaid or insurance for the purpose of billing and for any reason in accordance with acceptable medical practice pursuant to the law. I assign my insurance benefits to be paid directly to Jefferson County General Health District. I am financially responsible for non-covered services, but understand that services will not be denied due to inability to pay.

Guarantor Insurance:
Mother/guardian:_____ Birth Date:_____
Mother's SSN:_____ Work #:_____ Cell #:_____

Father/guardian: :_____ Birth Date:_____
Father's SSN:_____ Work #:_____ Cell #:_____

Patient's Home Address:_____
Patient's Home Phone #:_____
Guardian's Email Address:_____

Name of emergency contact in case parent cannot be reached:_____
Relationship to Patient:_____ Phone #:_____

Parent/Guardian Signature:_____ Date:_____

Insurance Information: Please send a copy of the insurance/medical card
Private Insurance
Name of insurance company:_____
Address:_____ City:_____ State:_____ Zip:_____
Phone #:_____ Employer/Company Name:_____
Name of Insured Employee:_____ Birth Date:_____ SSN:_____
Policy Number :_____ Group Number:_____

If possible please send a copy of the front and back of your child's insurance card.

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Medicaid	ID Number
☐ Straight Ohio Medicaid	_____
☐ Buckeye Community Health Plan	_____
☐ CareSource of Ohio	_____
☐ Molina of Ohio	_____
☐ Paramount	_____
☐ United Healthcare of Ohio	_____
☐ Anthem	_____
☐ Cigna	_____
☐ Medical Mutual	_____
☐ Health Plan	_____
☐ Aetna	_____
☐ Humana	_____

☐ No Insurance/Private Pay (A sliding fee scale is available for families that are uninsured. Charges are based on income and family size. A copy of the parent/guardian's proof of income must be on file with the application in order to be eligible).

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Child Informed Consent Form

I, _____, the parent/guardian of _____,
(Parent/Guardian's name) (Minor's Name)
grant permission to utilize the medical services offered through the school-based health center.

Initializing each line and/or signing below, you are acknowledging all of the following:

_____
(Initial)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

In general, any information that is about your health care you receive, or payment for that care, is considered confidential and protected by our practice. We may use your Protected Health Information to carry out treatment, payment, health care operations, and/or other purposes. Our "Notice of Privacy Practices" provides a more complete description of permitted uses and disclosures.

_____
(Initial)

ASSIGNMENT AND RELEASE OF BENEFITS

I hereby authorize payment directly to Jefferson County General Health District, for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, co-pays, and deductibles, whether or not paid by Insurance, and for all services rendered on my behalf or my dependents. I authorize the use of this signature on all insurance submissions.

_____
(Initial)

PATIENT LIABILITY FOR NON-COVERED/INELIGIBLE SERVICES

I understand that the services I will be provided with via my Healthcare Provider or office staff may or may not be covered by my insurance. I understand that it is my responsibility to know my individual insurance plan's covered services, and that the Jefferson County General Health District is not responsible to know whether my insurance will pay or require prior-authorization. If any services I receive at the facility at any time during my course of treatment are deemed non-covered or ineligible or any other reason unpaid, as well as all efforts are made to obtain payment from my insurance. I understand I am financially responsible for payment of the denied services.

_____
(Initial)

ELECTRONIC RECORD TRANSFER

I understand that it may be necessary to transmit my medical records/prescriptions electronically and I authorize to do so, I understand that if I need to transfer my medical records, that I am required to sign a separate authorization to release form. I absolve Jefferson County General Health District, and it's personnel of any liability relating to the transfer of said records.

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AUTHORIZATION TO TREAT

_____ (Initial)

I hereby authorize any provider employed as part of Jefferson County General Health District to administer such treatment and perform such procedures as may be deemed necessary or advisable in the diagnosis of this patient which may or may not be myself.

AUTHORIZATION FOR EXCHANGE OF HEALTH & EDUCATION INFORMATION

_____ (Initial)

I hereby authorize Jefferson County General Health District to exchange health and education records (including immunization records) with the appropriate school district for the purpose of providing care and treatment, if applicable.

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HIPPA RELEASE: I hereby authorize Jefferson County General Health District, providers and/or staff to discuss my medical information with the following person(s); this does not allow the release of records to this person(s):

Name	Relation to patient
Name	Relation to patient
Name	Relation to patient

_____ _____
Patient's/Guardian's Signature Date

_____
Relationship to patient

Email the completed forms to: Ashley@jchealth.com