DENNY INTERNATIONAL MIDDLE SCHOOL WELLNESS CENTER REGISTRATION

Today's Date _____ **Student ID #** _____

What services are you here for today? ☐ Family Planning ☐ Primary Care ☐ Mental Health

Name First_____ Last _____ Middle Name_____ Suffix Jr, Sr, I, II, III

Preferred Name or "Nickname" _____ **Social Security Number (OPTIONAL)** _____-_____-_____

Gender ☐ Female ☐ Male ☐ Other _____ **Date of Birth** _____

Address _____ **City**_____ **State**_____ **Zip Code** _____

Home Phone _____ May we call you at this number? ☐ Yes ☐ No

Student's Cell Phone _____ May we text you at this number? ☐ Yes ☐ No

Language Do you need an interpreter? ☐ Yes ☐ No If yes, what is your primary language? _____

Housing Status Have you been in safe and stable housing for the past year? ☐ Yes ☐ No

If "No" ☐ Transitional housing ☐ Living with others ☐ Shelter ☐ Street/Camp/Bridge

☐ Other please describe_____

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to answer

Race Please check all that apply ☐ Asian ☐ Alaskan Native ☐ American Indian ☐ Black orAfrican American

☐ Pacific Islander ☐ Hawaiian Native ☐ White ☐ Decline to answer

When is your last physical exam? Date: _____ **When is your last dental exam**? Date:_____

Primary Care Provider Do you have a current Primary Care Provider ☐ Yes ☐ No

If yes, who is your provider?_____

Insurance Information Do you have any type of medical or dental insurance coverage?

☐ **Yes** (please provide medical insurance card at check-in) ☐ **No**

If yes, please check all that apply

☐ Medicaid (**Apple Health**)

Insurance Information

☐ Commercial Insurance, please provide insurance coverage information below:

Name of Insurance	Group Plan Number	Member ID Number
Effective Date	Subscriber/Policy Holder Name	Subscriber Date of Birth

☐ Other_____

Emergency Contact Name_____Relationship_____

Legal Guardian ☐ Yes ☐ No Phone#_____Alternate Phone# _____

If No Who Is? _____

Please answer the health history questions if you know (Medical/Mental Health History)

Does the student have any medical problems or mental health concerns? _____

Does the student have any allergies to any medications? _____

Does the student need medication on a regular basis? _____

If yes, what medication? _____

Has anyone in the student's family had the following (**check all that apply**)? For any positives, please indicate who (i.e., brother, aunt, plus age of onset).

☐ Asthma _____

☐ Diabetes _____

☐ Heart Problems/Stroke _____

☐ Mental Health Problems _____

☐ Alcohol or Chemical use _____

☐ Cancer _____

☐ Seizures _____

☐ High Blood Pressure _____

☐ High Cholesterol _____

☐ Expired before 50 _____

NOT TO BE FILED INTO CLIENT'S HEALTH RECORD