# WARE Center School-Based TeleHealth

**STUDENT INFORMATION SHEET**

Date_____ Grade_____ Homeroom_____

**Patient information**

Name _____ Social security number_____

Sex: M / F Race_____ Date of birth_____ Age_____

Street address_____

City_____ State _____ ZIP code_____ County _____

**Guardian's information**

Name _____ Street address_____

City _____ State_____ ZIP code_____ County_____

Employer_____ Work number_____

Home phone_____ Cell phone_____ Other_____

**Emergency contact**

Name _____Relationship to patient_____

Street address _____ City_____ State_____ ZIP code_____

County_____ Home phone_____ Cell phone_____ Other_____

**This form must be completed along with insurance information in order for your child to get services at the WARE Center School-Based TeleHealth clinics.**

I hereby voluntarily give my consent for _____ to get services through WARE Center School-Based TeleHealth clinics. I authorize any doctor or designated health/mental health professional working for the WARE Center School-Based TeleHealth clinics to provide care.

**Parent/guardian signature**_____ **Date**_____

**MEDICAL HISTORY**

**Name of primary care physician**_____ Address_____ Phone number _____ Date last seen_____

**Name of dentist**_____ Address_____

Phone number_____ Date last seen_____

**Name of pharmacy**_____Address_____

Phone number_____

**List medication allergies**_____

**List all medical problems**_____

**List all past surgeries**_____

**Family medical history**

**Mother**_____**Father**_____

**Medication list (include dosage and time)** _____

_____

**Do you have any religious/personal beliefs that the WARE Center School-Based TeleHealth clinics should know about related to your care? If yes, please explain**_____

**PLEASE MARK ALL THAT APPLY**

**ENDOCRINE**

____ Swelling under arms or neck
____ Weakness and tiredness
____ Always hungry
____ Increased thirst
____ Increased urination
____ Tends to be too hot
____ Tends to be too cold
____ Frequent fever and chills
____ Night sweats
____ Problems going to sleep
____ Problems waking up after falling asleep
____ Recent weight gain
____ Recent weight loss
____ Diabetes
____ Other_____

**INFECTIONS**

____ Chickenpox
____ Hepatitis B
____ Hepatitis C
____ HIV/AIDS
____ Other_____

**PULMONARY**

____ Chronic snoring
____ Persistent cough
____ Coughing up blood
____ TB (or exposure to)
____ Sleep apnea
____ COPD, emphysema or chronic bronchitis
____ Asthma
____ Other_____

**NEUROLOGY**

____ Frequent headaches
____ Migraines
____ Seizures
____ Stroke or paralysis
____ Memory problems
____ Meningitis
____ Nerve damage to feet/hands
____ Other_____

**CARDIOVASCULAR**

____ Chest pain
____ Heart palpitations
____ Dizziness upon standing

**EARS, NOSE and THROAT**

____ Wears glasses or contacts
____ Eye drainage
____ Blurry vision
____ Recent changes in vision
____ Decreased hearing
____ Earache or drainage
____ Ringing in ears
____ Allergies (Seasonal)
____ Sinus problems
____ Frequent nosebleeds
____ Frequent sore throat
____ Tongue/mouth sores
____ Goiter/thyroid problems
____ Neck pain or lumps
____ Any change in voice
____ Dental problems
____ Other_____

**HEMATOLOGY**

____ Anemia/low blood count
____ Sickle cell disease
____ Bleeding/bruising easily
____ Cancer (Please list _____)
____ Chemo/Radiation exposure
____ Other_____

**MUSCULOSKELETAL**

____ Gout
____ Frequent pain in fingers or hands
____ Muscle or joint pain
____ Leg cramps with exercise
____ Leg cramps at night
____ Arthritis
____ Other_____

**GASTROINTESTINAL**

____ Frequent heartburn
____ Decreased appetite
____ Frequent nausea or vomiting
____ Liver disease
____ Jaundice or hepatitis
____ Difficulty swallowing
____ Stomach pain
____ Recent change in bowel habits
____ Frequent diarrhea
____ Frequent constipation
____ Incontinence
____ Bloody stools
____ Rectal pain

____ Swelling in feet/hands
____ High blood pressure
____ High cholesterol
____ Fainting spells
____ Shortness of breath with exercise
____ Heart murmur
____ Other_____

**BEHAVIORAL/MENTAL**

____ Nightmares
____ Bedwetting
____ Eating problems
____ Thumb sucking
____ Discipline problems
____ Overactive/hyperactive
____ Shyness/social avoidance
____ Sleeping problems
____ Developmental delays
____ Learning disabilities
____ Depression
____ Anxiety
____ Cries often
____ Feels sad
____ Hears voices
____ Anger
____ Diagnosed behavioral/mental disorder
(Please list_____)
____ Tobacco use
____ Inhalant use
____ Alcohol use
____ Drug use

**GENITOURINARY**

____ Frequent urination
____ Burning when urinating
____ Difficulty starting urination
____ Incontinence
____ Kidney stones
____ Kidney disease
____ Other_____

____ Hemorrhoids
____ Rectal fissure
____ Parasites or worms
____ Pancreatitis
____ Other_____

**MALE ONLY**

____ Weak urine stream
____ Prostate problems
____ Lump on testicle(s)
____ Sexual difficulty
____ Sexually transmitted disease(s)
____ Other_____

**FEMALE ONLY**

____ Pregnancies
____ Miscarriages
____ Cesarean section
____ Hysterectomy
____ High blood pressure
during pregnancy
____ Diabetes during pregnancy
____ Lump in breast(s)
____ Menstrual problems
____ Sexual difficulty
____ Sexually transmitted disease(s)
____ Other_____

**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 controls the use and sharing of Protected Health Information (PHI). We're required to share this notice with you. We hope you'll read the information about our privacy practices. It's your copy, so feel free to keep it.

I acknowledge that I received the HIPAA Notice of Privacy Practices from the WARE Center School-Based TeleHealth Clinic.

**Patient/parent/guardian signature_____ Date_____**

**All medical history is true and correct to the best of my knowledge.**

**AUTHORIZATION TO BILL INSURANCE**

Patient's name_____

Patient's date of birth _____ Patient's Social Security number _____

**Primary insurance company** _____

Name of person insured _____

Insured's date of birth _____ Insured's Social Security number_____

Group number_____ Policy or member number _____

**Secondary insurance company** _____

Name of person insured _____

Insured's date of birth _____ Insured's Social Security number_____

Group number _____ Policy or member number_____

**Responsible party**

Name_____ Date of birth_____

Social Security number _____ Employer _____

**A COPY OF YOUR INSURANCE CARD IS REQUIRED**

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

**Patient/parent/guardian signature_____ Date_____**

**Lab Permission Form**

*Mayo Clinic Health Services of Waycross*
*410 Darling Ave.*
*Waycross, GA 31501*

I allow Mayo Clinic Health Services of Waycross to perform venipuncture (blood work) and lab tests on my child as called for by a licensed doctor.

I understand that my insurance carrier will be billed, and any deductible/balances will be my responsibility.

I understand that the ordering doctor will be the only doctor to have access to these results unless requested otherwise.

**Patient/parent/guardian signature** _____ **Date**_____

**Mayo Clinic Health Services of Waycross offers lab services for your convenience.**
**You have the right to use the lab of your choice.**
**Please remember to attach a copy of your insurance card. Thank you!**