HealthHUB School Clinic

PO Box 542, South Royalton, VT 05068

Medical Enrollment Form

Parent/Guardian: Please complete this and the Pediatric Health History form.

Office use only:
Student ID # ____________________
Enrollment date ____________________
Info update ____________________

Authorization

I give my child permission to receive health care services at HealthHub. I authorize and consent to the prevention, diagnosis, treatment, and follow-up deemed necessary for my child's care. These services may include:

- Physical exams
- Written prescriptions
- Minor lab procedures
- Nutrition and weight counseling
- Identification of health risks and plans to reduce risks
- Mental health counseling
- Monitoring of chronic conditions
- Referrals for specialty services or services not offered
- Dental cleanings/screenings
- Immunizations.

HealthHub will provide any medical information to your insurance company as necessary to bill and substantiate the services your child received. You agree that HealthHub may bill your insurers and they may make their payments directly to the South Royalton Clinic. You will be billed for charges not covered by your insurance.

HealthHub will provide medical information to your primary care physician and referral health care providers as necessary to continue your child's medical care.

Patients have specific rights under state and federal law.

This permission will remain in effect until the child turns 20 or until parents rescind permission in writing.

Signature of Parent/Guardian ____________________

Date ____________________

Student's Name:
Last ______
First ______
Middle ______
☐ Male ☐ Female

Student's Race: *Please check one*
☐ White/Non-Hispanic ☐ Black/Non-Hispanic
☐ Hispanic ☐ Native American/Alaskan Native
☐ Asian/Pacific Islander ☐ Unknown
☐ Other (specify) ______

Student's Address and Phone:
Address ______
City ______
State ______ Zip ______
Home phone (____) ______

Student's Date of birth ______

Student's Social Security ______

Student's Grade in School: ______

Mother/guardian's Name
______
Home phone (____) ______
Work phone (____) ______

Father/guardian's Name
______
Home phone (____) ______
Work phone (____) ______

Emergency Contact *if above unavailable*
Home phone (____) ______
Work phone (____) ______

With whom does the Student Live? *Check all that apply*
☐ Mother ☐ Stepmother ☐ Father
☐ Stepfather ☐ Guardian/Foster Parent
☐ Grandparent ☐ Sister/Brother
☐ Alone ☐ Own children
☐ Other ______

Student's Usual Source of Medical Care
Name of primary care provider and clinic
______
Address ______
Phone (____) ______
Date of last visit ______

Has the student seen a health care provider (e.g. physician or nurse practitioner) in the last year?
☐ Yes ☐ No. If yes, how many visits? ______
What were the main reasons for these visits?
______

Has the student been seen in a hospital emergency room in the past year?
☐ Yes ☐ No. If yes, how many visits? ______
What were the main reasons for these visits?
______

Medical Insurance *Check one*
☐ Medicaid/Dr. Dynasaur ☐ Private insurance
☐ Uninsured/self pay

Student's Insurance ID #s
Medicaid # ______
Personal ID # ______

Primary Insurance:
Company ______
Address ______
City ______ State ____ Zip ______
Phone (____) ______
Group name ______
Group # ______
Certificate # ______
Copay requirements ______

Secondary Insurance
Company ______
Address ______
City ______ State ____ Zip ______
Phone (____) ______
Group name ______
Group # ______
Certificate # ______
Copay requirements ______

Policy Guarantor (holder, subscriber)
Name ______
Address ______
City ______ State ____ Zip ______
Phone (____) ______
Date of birth ______
Effective date of enrollment ______
Relationship to student ______

Student's Usual Source of Dental Care
Name of dentist and clinic
______
Address ______
City ______ State ____ Zip ______
Phone (____) ______
Date of last visit ______

Dental Insurance Company
Company ______
Address ______
City ______ State ____ Zip ______
Phone (____) ______
Policy # ______