Northwest Michigan Health Services, Inc.

Child Adolescent Health Center

Student General Information

First Name: | Middle Initial: | Last Name:

Student's Address: | City: | State: | Zip:

Grade: | Homeroom #: | Birthdate: | Email address:

Student's Phone:

Can we text appointment reminders to **Student:** ☐ Yes ☐ No

What is the best way to reach the student? ❑ Phone ❑ Text ❑ Email

Name of Student's Pharmacy: Phone Number:

Parent Information

Mother/Guardian: | DOB: | Cell Phone:

Email:

What is the best way to reach you: ☐ Cell phone ☐ Home Phone ☐ Text ☐ Email

Can we text appointment reminders: ☐ Yes ☐ No

Do you authorize our staff to leave a voicemail regarding treatment, test results or other necessary information (excluding confidential services)? ☐ Yes ☐ No

Father/Guardian: | DOB: | Cell Phone:

Email:

What is the best way to reach you: ☐ Cell phone ☐ Home Phone ☐ Text ☐ Email

Can we text appointment reminders: ☐ Yes ☐ No

Do you authorize our staff to leave a voicemail regarding treatment, test results or other necessary information (excluding confidential services)? ☐ Yes ☐ No

Parent/Guardian Address: | City: | State: | Zip:

Emergency Contact (Non-Household Member): Relationship: | Phone #:

FQHC-Required Demographic Information

It is the policy of NMHSI to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

Race: ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Pacific Islander ☐ Other: _____

☐ Native American/Alaska Native- Tribal Member: ☐ Yes ☐ No Descendent: ☐ Yes ☐No Name of Tribe: _____

Ethnicity: Hispanic or Latino Non-Hispanic or Latino ☐ Other: _____ | Preferred Language:

Are you a veteran? ☐ Yes ☐ No | Are you homeless? ☐ Yes ☐ No | Do you need an Interpreter: ☐ Yes ☐ No

Do you work in Agriculture? ☐ Migrant Worker ☐ Seasonal Worker ☐ None

This Section to be Completed for Patients 18 Years of Age and Over

Sexual Orientation: ☐ Straight ☐ Bisexual ☐ Lesbian/Gay ☐ Something Else ☐ Don't Know ☐ Choose not to Disclose

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male (F→M) ☐ Transgender Female (M→F) ☐ Choose not to disclose ☐ Other

Income Information & Health Insurance Information (we will bill your insurance for services)

Federal Regulations require that we report the ***combined total*** of all household members' income for those seeking care at NMHSI. We ask your cooperation in indicating the following:

Total Number in Household: _____ Your yearly combined household income is: $_____

Even if the student has insurance, the student may qualify for NMHSI's sliding fee scale, which offers discounted fees for services.
Do you want to apply to see your qualifications? ☐ No ☐ Yes

Does the student currently have health insurance? ☐ Uninsured ☐Medicaid ☐Private

Policyholder's Name: _____ DOB: _____ Insurance Carrier:_____

Policy #: _____ Group #: _____

_____ _____ _____

Signature of Parent/Guardian/Patient age 18 and older | Print Name | Date

Revised: 05/25/2021