Valley-Wide Health Systems, Inc.

School Based Health Enrollment Form

PATIENT INFORMATION Childs Legal Name

_____

(Last) (First) (M.I)

_____

(Birth Date) Sex: Male ◯ Female ◯

_____

Parent or Guardian Name (Parent/Guardian Birth Date)

_____

Billing Address City

_____

State Zip

_____

Secondary Address City

_____

State Zip

(____)_____(_____)_____

Primary Phone Secondary Phone

_____

E-mail Address

_____(_____)_____

Emergency contact name Phone

_____(_____)_____

Guarantor (person responsible for payment) Phone

_____

Guarantor Address

Preferred Language _____

Homeless Yes ◯ No ◯

Do you reside in public housing Yes ◯ No ◯

Race

White ◯ Asian ◯
Black/ African American ◯
Other ◯ Refused ◯
Unknown ◯

Ethnicity

Hispanic or Latino ◯
Not Hispanic or Latino ◯
Other ◯ Refused ◯
Unknown◯

MEDICAL INFORMATION

Primary Medical Provider:_____

Primary Dental Provider:_____

Dose your child see a doctor for regular check ups. YES ◯ NO ◯

When was the last time your child saw a dentist? ◯ Never

◯ Over 5 years ◯ 3-5 years ◯ 1-3 years ◯ less than a year

Medical Insurance Name:_____

Policy Number:_____

Group Number:_____

Dental Insurance Name:_____

Policy Number:_____

Group Number:_____

Would you be willing to provide the following information?

Yes ◯ No ◯

Family Size_____ Monthly income $_____

Why do we ask? We are a federally Qualified Healthcare Center (FQHC). Our federal funding that we receive to enhance our services is based off these numbers.

Are you or a family member a agricultural worker?_____

In the last 24 months have you or a member of your family

Been hired to do agricultural (Ag) work ? Yes ◯ No ◯

Is the majority of your income from Ag work ? Yes ◯ No ◯

Moved temporarily to do Ag work? Yes ◯ No ◯

Have you stopped working in Ag due to age or disability? Yes ◯ No ◯