School Telehealth Patient Information Form

Patient Information

*Child's Last Name | *Child's First Name | Child's Middle Name

*Gender | *Child's Date of Birth | Social Security Number

☐ Male ☐ Female

*Street Address

*City | *State | *Zip code

*Preferred Pharmacy Name | *Street/Address

*Pediatrician/PCP | *PCP Phone #

*School District | *School Name

Race/Ethnicity (Select appropriate group):

Asian ☐ Black/African American ☐ Latino/Hispanic ☐ Native American ☐
☐ White/Caucasian ☐ Other

* Allergies (Type N/A if this does not apply)

*Medical History/Surgical History

PARENT/GUARDIAN INFORMATION

*Child Lives With:

Mother & Father ☐ Mother ☐ Father ☐ Guardian/Other ☐

*Parent/Guardian's Last Name | *Parent/Guardian's First Name | Middle Initial

*Parent/Guardian Date of Birth | *Primary Phone Number | Alternate Phone Number

*Email Address ☐ Opt out of email contact (Check box to opt out)

EMERGENCY CONTACT

In case of an emergency, who should we contact

*Emergency Contact Full Name

*Emergency Contact Phone Number | *Relationship to Patient:

INSURANCE INFORMATION

*Select the type of Insurance for the patient: Commercial Insurance ☐ CHIP ☐ Medicaid ☐ None ☐

Insurance Name | Insurance ID Number | Group Number

*Name of Responsible Party | *Primary Phone Number

*Responsible Party Address

*City | *State | *Zip Code

*Relationship to Child

Father ☐ Mother ☐ Other ☐

*Responsible Party Date of Birth

*Printed Name of Patient/Parent or Legally Authorized Representative | *Relationship to Patient

Signature of Patient/Parent or Legally Authorized Representative | Today's Date & Time

Date | Time