Methodist Healthcare Ministries | GEORGE RICKS SCHOOL-BASED HEALTH CENTER

PROGRAMS & SERVICES INCLUDE

- Diagnosis and treatment of simple illness or injury
- Immunizations
- Well child exams
- Physical exams
- Sports physicals
- Health promotion and education
- Prescription assistance
- Preventative dental care including examinations, x-rays, cleanings, fluoride treatments and sealants
- Dental treatment including fillings, extractions and endodontic treatment available
- Sports mouthguards (in school colors)
- Counseling for students and their families
- Support groups
- Case management services
- Food assistance
- Assistance with Medicaid, CHIP and SNAP applications
- Referrals to other community resources
- Rent and utilities assistance for families of students

TO SCHEDULE AN APPOINTMENT, CONTACT:

George Ricks School Based Health Center
at Schertz Elementary
757 Curtiss Avenue
Schertz, TX 78154
(210) 658-4875

George Ricks School Based Health Center
at Krueger Elementary
217 West Otto Street
Marion, TX 78124
(830) 420-2291

Clinical services are charged on a sliding fee scale based on annual household income. We see all students in the school district regardless of insurance or ability to pay.

ABOUT US

The George Ricks School Based Health Centers provide pediatric primary health care, dental care, and a comprehensive range of services to children enrolled in the Marion and Schertz-Cibolo-Universal City Independent School Districts, as well as their siblings up to age 21. Clinical services provided at the George Ricks School Based Health Centers are charged on a sliding fee scale based on annual household income.

At Methodist Healthcare Ministries, our goal is to help every patient thrive. We do this by listening carefully and putting each person's needs at the center of their health care. Whether it's physical or emotional pain and stress, our compassionate team works together to help them live healthier lives.

REV 02/2023

Please only use a blue or black ink pen to complete this form.

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GEORGE RICKS SCHOOL BASED HEALTH CENTER REGISTRATION FORM

Patient Information

Full name:_____ Date:_____

Social security number:_____ Date of birth:_____ Gender: ☐Male ☐Female

Address: _____

City:_____ County:_____ State:_____ Zip: _____

Phone:_____ Alternate number: _____

School:_____ Grade:_____ Teacher:_____

Ethnicity: ☐Caucasian ☐Hispanic ☐African-American ☐Asian Other: _____

Primary language: ☐English ☐Spanish Other: _____

Household Information

Mother/guardian's name:_____ Relationship:_____

Social security number:_____ Date of birth: _____

Father/guardian's name:_____ Relationship: _____

Social security number:_____ Date of birth: _____

Parent's marital status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widow/Widower

Parent's work status: ☐Full-time ☐Part-time ☐Retired ☐Unemployed

Insurance Information

Does your child have any of the following type of insurance coverage? *Please check all that apply*:

Medicaid ☐Yes ☐No Medical insurance ☐Yes ☐No CHIP ☐Yes ☐No Dental insurance ☐Yes ☐No

Preferred pharmacy: _____

If the child is receiving Medicaid, CHIP or does not have insurance, please provide the following information:

Estimated annual gross income: $_____ Number of people in household: _____

Social History

Who lives in the household? Members in the household (please list names and relationship):

_____ _____

_____ _____

_____ _____

Smokers in the household? ☐Yes ☐No If yes, ☐Indoor ☐Outdoor

Child's Medical History

Is your child allergic to latex? ☐Yes ☐No

Does your child have food or drug allergies? ☐Yes ☐No If yes, specify: _____

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Were there any problems with mother's pregnancy with this child? ☐Yes ☐No

If yes, please explain: _____

Child's birth: ☐Term delivery ☐Premature birth Weight:_____Birth complications: _____

Child hospitalizations: ☐Yes ☐No If yes, diagnosis and dates: _____

Child surgeries: ☐Yes ☐No If yes, types and dates: _____

Child's Chronic Health Problems

Rheumatic fever	☐Yes ☐No	Skin	☐Yes ☐No	Trauma	☐Yes ☐No
Gastrointestinal	☐Yes ☐No	Hepatitis	☐Yes ☐No	Asthma/Bronchitis	☐Yes ☐No
Genetic syndrome	☐Yes ☐No	Urinary	☐Yes ☐No	Seizures	☐Yes ☐No
Ear infections	☐Yes ☐No	Dental	☐Yes ☐No	ADD/ADHD	☐Yes ☐No
Visual	☐Yes ☐No	Hearing	☐Yes ☐No	Developmental	☐Yes ☐No
Anemia	☐Yes ☐No	Bleeding	☐Yes ☐No	Heart	☐Yes ☐No
Allergies/Sinus	☐Yes ☐No	Cancer	☐Yes ☐No	Infectious disease	☐Yes ☐No
Diabetes	☐Yes ☐No	Orthopedic (broken bones)	☐Yes ☐No	Mental health issues	☐Yes ☐No

Other:_____

Explain all marked answers:

_____

_____

Current medication (name/dose):

_____

_____

Family Medical History (siblings, parents, grandparents)

Heart disease	☐Yes ☐No	Asthma	☐Yes ☐No	Kidney disease	☐Yes ☐No
High blood pressure	☐Yes ☐No	Seizures	☐Yes ☐No	Diabetes	☐Yes ☐No
Mental health issues	☐Yes ☐No				
Cancer	☐Yes ☐No	If yes, please specify type of cancer: _____			

Other: _____

Signature

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal guardian signature:_____Date: _____

Reviewed by:_____Date: _____
To be completed by Methodist Healthcare Ministries staff or personnel.

Please only use a blue or black ink pen to complete this form.

Consent for George Ricks School-Based Treatment, Services and Communication

Date: _____ **Patient's Name**: _____ **Date of Birth**: _____

I give permission to Methodist Healthcare Ministries of South Texas, Inc. (MHM) to provide my child the services checked below:

I authorize MHM's George Ricks School Based Health Center to provide:

☐ Yes	☐ No	Medical Services
☐ Yes	☐ No	Dental Services
☐ Yes	☐ No	Social Services
☐ Yes	☐ No	Counseling

I authorize MHM to pull my child out of class with scheduled appointment

☐ Yes	☐ No	Medical Services
☐ Yes	☐ No	Dental Services
☐ Yes	☐ No	Social Services
☐ Yes	☐ No	Counseling

I authorize MHM's George Ricks School Based Health Center Providers to release information to:

☐ Yes	☐ No	The school **athletic program** (sport's physical form only)
☐ Yes	☐ No	The school nurse

Consent for Communication

I ☐ **Do NOT consent** to MHM contacting me for appointment scheduling, appointment reminders, virtual appointments, and other wellness promotion reasons.

I ☐ **Do consent** to MHM contacting me for appointment scheduling, appointment reminders, virtual appointments, and other wellness promotion reasons. I understand that I may be contacted by an MHM team member or an Automated Telephone Dialing System (ATDS).

☐ **Non-Cellular (landline) Telephone**
The non-cellular telephone number that I authorize to receive
☐ **Voice Messages**
is: (___)____-____

☐ **Cellular Telephone** - standard text messaging rates may apply as provided in your wireless plan.
The cellular telephone number that I authorize to receive
☐ **Voice Messages** ☐ **Text Messages**
is: (___)____-____

I understand that text messages are sent over a public network to a personal telephone and may not be secure. However, I am aware that MHM will not transmit any information which would enable me to be identified.

☐ **The EMAIL** that I authorize to receive messages is:

_____@_____

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Consent for George Ricks School-Based Treatment, Services and Communication

Date: _____ **Patient's Name**: _____**Date of Birth**: _____

Privacy Practices

I understand that my medical records are kept electronically. At times, Methodist Healthcare Ministries of South Texas, Inc. (MHM) might share my medical information with other parties involved in my care for the purposes of:

- Treatment (example: two doctors working together in my treatment)
- Health operations-to improve the services that MHM provides

I can find more information about this in the Notice of Privacy Practices on MHM.org.
☐ **I have received a copy of the Notice of Privacy Practices.**

Rights and Responsibilities

☐ **I have received information about my rights and responsibilities as a patient/client of Methodist Healthcare Ministries.**
This consent form has been explained to me. I understand what I am consenting to. I further understand that I may revoke this authorization at any time.

Health Information Exchange (HIE)

MHM submits healthcare information to Health Information Exchanges (HIE), which helps us provide better care by:

- Coordinating care/services with other providers and hospitals to prevent gaps in your care

Your medical information will be provided to one or more Health Information Exchanges. If you choose not to participate in the Health Information Exchange, you can do so by checking the box below. You will still qualify for MHM services.

☐ **No, I do not want my medical information shared with any Health Information Exchange.**

Patient's /Client's Signature: _____ Date: _____

Parent/Guardian Signature_____ Date: _____

Relationship to the Patient/Client: _____