

**Bangor Health Center and E3 program at South Walnut**  
**Open Year Round to serve youth ages 5-21**

803 West Arlington, Bangor, MI 49013/309 S. Walnut, Bangor  
Phone: 269-427-6810 Health Center/269-427-6800 x 8142 South Walnut Fax: 269-427-6811

**REGISTRATION AND CONSENT**

**Child/Patient Name:** \_\_\_\_\_  
First Middle Initial Last  
**Patient Date of Birth:** \_\_\_\_\_ **Male** ☐ **Female** ☐ **Gender** \_\_\_\_\_  
**Mailing Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Patient's Phone Number:** \_\_\_\_\_ ☐ Home ☐ Cell ☐ Other: \_\_\_\_\_

Providing the following information is strictly voluntary and is not required for registration.

**Race:**

☐ Caucasian ☐ Black ☐ American Indian ☐ Bi/multi-racial ☐ Asian ☐ Other:

**Ethnicity:**

☐ Hispanic ☐ Arab ☐ Non-Arabic/NonHispanic

**1<sup>st</sup> Parent/Guardian Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Best way to reach you during the day?** Home/Cell/Work/Other (circle) **May we leave a message?** Yes/No (circle)

**2<sup>nd</sup> Parent/Guardian Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Best way to reach you during the day?** Home/Cell/Work/Other (circle) **May we leave a message?** Yes/No (circle)

**Emergency Contact:** \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Dentist:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**By signing this form, I certify I am the legal guardian of the above-named patient and give my consent for the above named patient to receive all services (listed on page 2) at Bangor Health Center and/or E3 program at South Walnut (E3 is Mental Health services only). By signing this consent, you understand your child may seek care on their own. Your participation is encouraged and parents are always welcome. This consent is valid until the patient turns 18, at which time s/he legally consents for their health care. **Consent for services may be withdrawn upon written notice to Bangor Health Center at any time.****

**ASSIGNMENT of BENEFITS:** I hereby assign all medical benefits be made directly to Van Buren Community Mental Health Authority on my behalf, for any services provided to the above named person. I authorize any holder of medical and other information about my child, to release to Medicaid and its agents, any insurance company, any other third party, state medical assistance agency, or any other governmental or private payor responsible for paying such benefits, any information needed to determine these benefits, or benefits for related services. I authorize a copy of this authorization to be used in place of the original. I further authorize both Bangor Health Center and my child's primary care physician to exchange health care information for the purpose of continuity and coordination of care. I give Bangor Health Center authorization to obtain a copy of the above named student's immunization record from the Michigan Care Improvement Registry (MCIR), school office, or primary care provider. Release or exchange of information for other purposes will require a separate Release of Information form to be signed. *If you would like a copy of the Notice of Privacy Practices, please notify our office.*

**SIGNATURE OF PARENT/GUARDIAN or PATIENT (18 or older):** \_\_\_\_\_ **DATE:** \_\_\_\_\_

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**INSURANCE INFORMATION-Please fill this section out for our billing purposes even though there is no charge to you for our services.**

All medical and counseling visits are recorded in the electronic medical record and a claim will be generated to the health insurance. We accept insurance payment as payment in full. **We do not bill patients for their portion of the claim. Patients without insurance are served at NO charge. Staff are available to assist with applying for Medicaid if needed, please inquire.**

**Primary Insurance:**

Health Insurance Plan: \_\_\_\_\_  
Contract #/Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Address (if known): \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
First Last  
Policy Holder's Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**Secondary Insurance:**

Health Insurance Plan: \_\_\_\_\_  
Contract #/Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Address (if known): \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
First Last  
Policy Holder's Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**\*\*\* Please alert Bangor Health Center of any change in insurance information \*\*\***

**SERVICES**

**SERVICES PROVIDED:**

- Well child exams and comprehensive physicals for school, sports, and camp
- Treatment for acute & chronic illness & injuries
- Mental health Counseling
- Immunizations with parent contact!
- In-house and send out laboratory services
- Most prescriptions
- Some in-house medications and treatments
- Health screening and education
- Prevention counseling for pregnancy and STI
- Referrals for specialty services
- Assistance with Medicaid enrollment

**SERVICES NOT PROVIDED:**

- Prescriptions for birth control medications or devices
- Prescription for controlled medications
- Abortion counseling, service or referral

***\*Current Michigan State Law allows for confidential services to youth in these areas:***

- \*Pregnancy testing and referrals
- \*Screenings, treatment, counseling and referral related to sexually transmitted infections
- \*HIV screening and referrals
- \*Physical/sexual abuse counseling and referrals
- \*Crisis intervention
- \*Substance abuse education, counseling and referrals
- \*Brief mental health assessment, counseling, and referrals (14 years and older)

~Services are provided regardless of ability to pay or insurance status.  
~Bangor Health Center treats all eligible patients regardless of sex, race, creed, color, religion, national origin, sexual orientation, gender identity or expressions, or disability.

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Phone: 269-427-6810 Health Center/269-427-6800 x 8142 South Walnut Fax: 269-427-6811**HEALTH HISTORY**Please fill out this Health History Questionnaire for your child/adolescent. **Today's Date:** \_\_\_\_\_**Child's name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Current Grade:** \_\_\_\_\_**Patient's Primary Care provider:** \_\_\_\_\_**Date of last physical:** \_\_\_\_\_**Patient's specialist (ex. cardiologist, endocrinologist, psychiatrist etc. - leave blank if patient does not see specialist):** \_\_\_\_\_**Preferred Pharmacy:** \_\_\_\_\_**Who lives in the home?**

Name:

Relationship:

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**Medications:** ☐ My child does not take any medications

Name of medicine: \_\_\_\_\_ Dose: \_\_\_\_\_ Reason for taking: \_\_\_\_\_ Prescribed by: \_\_\_\_\_

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**Allergies:** ☐ My child does not have any allergies to any medications

Name of medicine: \_\_\_\_\_ What type of reaction: \_\_\_\_\_

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**Patient's Health Conditions:** Please check yes or no related to the patient's health**Yes                      No                      Unsure**

|                       |       |
|-----------------------|-------|
| Asthma                | _____ |
| Depression / Anxiety  | _____ |
| Learning Disability   | _____ |
| Diabetes              | _____ |
| Heart Problems/Murmur | _____ |
| Seizures / Epilepsy   | _____ |
| Other (specify)       | _____ |

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**Has your child ever been hospitalized overnight, had any serious injuries including sports-related injuries, or had any type of surgery?**

☐ No: ☐ Yes: If yes, what age? \_\_\_\_\_

Problem/Type of Surgery? \_\_\_\_\_

**Family History:**

Some health problems are passed from one generation to the next. Have you or your adolescent's blood relatives (parents, grandparents, brothers, or sisters), living or deceased, had any of the following problems?

☐ Unknown family history

☐ Adopted

**Yes      No      Unsure      Relationship**

Allergies/Asthma

\_\_\_\_\_

Cancer (type)

\_\_\_\_\_

Depression

\_\_\_\_\_

Diabetes

\_\_\_\_\_

Heart Attack or stroke

\_\_\_\_\_

*Before age 50*

High blood pressure

\_\_\_\_\_

High cholesterol

\_\_\_\_\_

Mental illness

\_\_\_\_\_

Migraine headaches

\_\_\_\_\_

Smoking

\_\_\_\_\_

Substance Abuse

\_\_\_\_\_

Others (specify)

\_\_\_\_\_

Specific Services:

**Immunizations (vaccines): I understand my child's immunization records from the Michigan Care Improvement Registry (MCIR) will be reviewed. If it is determined that my child needs a vaccination, I will be contacted by Medical Professional to offer these services. NO immunizations will be given without prior consent.**

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## **Your Rights**

- You have the right to be treated with respect and dignity.
- You have the right to receive care in our program: regardless of race, religion, national origin, gender, sexual orientation, ability to pay or handicap.
- You have the right to privacy.
- You have the right to discuss with your healthcare provider any questions or problems you may have.
- You have the right to refuse any treatment you do not want or do not understand, unless you are a danger to yourself or others.
- You have the right to understand why certain information is requested or why certain care is suggested.

## **Your Responsibilities** **What you need to do....**

- You are responsible for treating health care providers with respect.
- You are responsible for answering questions and telling the truth about your health.
- You are responsible for showing respect and privacy for others using the program.
- You are responsible for asking questions about anything you do not understand.
- You are responsible for telling Bangor Health Center staff about any changes in your health.