CHI St. Joseph Children's Health

BEHAVIORAL HEALTH CENTER NEW PATIENT FORM

Please print clearly and use pen when completing this form.

Child Information:

Child's Name Last	First	Middle Initial	**Preferred Name/Nickname**	
Whom may we thank for referring you?			**Date of Birth** (MM/DD/YYYY)	**Age**
			Social Security Number	
Child's Race ☐ American/Alaskan Native ☐ Asian ☐ Black, incl. African-American	☐ Hawaiian/Pacific Islander ☐ More than one ☐ White ☐ Other _____		**Child's Ethnicity** ☐ Hispanic/Latino ☐ Not Hispanic/Latino	
Child's School			**Child's Sex** (check one) ☐ Male ☐ Female	

Parent/Contact Information:

Home Phone ☐ leave messages ( )	**Cell Phone** ☐ leave messages ( )	**Work Phone** ☐ leave messages ( )	**Best Number to Use** ☐ Home ☐ Cell ☐ Work
Address Street	City	State	ZIP Code
Child lives with (please check one) ☐ Both Parents ☐ Mother ☐ Father ☐ Other (please specify):			
E-Mail Address ☐ Okay to contact via e-mail			**Text Message Reminders** ☐ Yes ☐ No
Parent's or Guardian's Name		Phone Number	Relationship to Child
Parent's or Guardian's Name		Phone Number	Relationship to Child
Emergency Contact Name		Phone Number	Relationship to Child
May CHI St. Joseph Children's Health send mail to you at your address?* ☐ Yes ☐ No *This question refers only to mail other than billing and service statements.			

Household and Insurance Information:

This information assists CHI St. Joseph Children's Health in determining eligibility and additional programs for which you may qualify.

Annual Household Income ☐ <$9,999 ☐ $10,000 – $14,999 ☐ $15,000 – $19,999 ☐ $20,000 – $29,999 ☐ $30,000 – $49,999 ☐ $50,000 – $79,999 ☐ Over $80,000	Number of individuals in the household ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ Other_____	Child's Primary Spoken Language(s) ☐ English ☐ Español ☐ Français ☐ Português ☐ American Sign Language ☐ Other_____	Household Veteran Status ☐ Veteran (Relation: _____) ☐ Not a Veteran
Insurance Status ☐ Medicaid ☐ CHIP ☐ Private/Commercial ☐ No Insurance Coverage* *Please complete a The St. Joseph Access Plan – Discount Program Application.	If enrolled in Medicaid: Medicaid ID#_____ ☐ *Aetna Better Health* ☐ *Amerihealth Caritas* ☐ *Gateway* ☐ *United Healthcare - Families* ☐ *UPMC for You*	If enrolled in CHIP: CHIP ID#_____ ☐ *Aetna Better Health Kids* ☐ *Capital Blue Cross* ☐ *Geisinger Kids* ☐ *Highmark Blue Shield* ☐ *United Healthcare - Kids* ☐ *UPMC for Kids*	If enrolled in Private/Commercial: Member ID#_____ ☐ *Aetna* ☐ *Capital Blue Cross* ☐ *Geisinger* ☐ *Highmark* ☐ *UPMC* ☐ *Other*_____

Enrollment Form continues ⟶

Child Medical History:

Name of Doctor/Practice: _____ Phone #: _____

Child's Height: _____ Child's Weight: _____

My child has/had any history of: (please check all that apply) Indicate none by circling: None

☐ Bleeding Disorder	☐ ADHD/ Hyperactivity	☐ Liver Problems	☐ Recent Hospitalization/ Surgery
☐ Cancer	☐ Asthma/ Respiratory Problems	☐ Thyroid Problems	☐ Mental/Behavioral Health Concerns: Specify
☐ Cardiovascular / Heart Murmur	☐ Autism	☐ Sexually Transmitted Infections	
☐ Hepatitis A, B or C	☐ Cerebral Palsy	☐ Other:	
☐ HIV/AIDS	☐ Diabetes		
☐ Pregnant	☐ Epilepsy / Convulsions / Seizures	_____	
☐ Sickle Cell	☐ GI / Stomach Problems		
☐ Steroid Use (Oral ie. Prednisone)	☐ Kidney Problems		

Current Medications: Indicate none by circling: None

Please list any medications (including non-prescription drugs, vitamins and herbal supplements) that the child is taking.

	Medication Name	Dose	Frequency of Use
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Allergies: Indicate none by circling: None

Please list any allergies the child may have, including allergies to medications and foods.

HIPPA Privacy Notice, Treatment Consent, Financial Policy, and Cancellation Acknowledgement

I agree that, to the best of my knowledge, all information on this form is accurate and true. I acknowledge that I have received the HIPAA Privacy Notice. I attest that I have received and read the Consent for Treatment, the Appointment Cancellation Policy, and the Financial Policy or have had it explained to me.

☐ I am the parent/guardian of the child named on this application, and I am authorized to knowingly consent for treatment on behalf of the named child.

☐ I am the patient named on this application, and I am knowingly consenting for treatment **(This option should be selected for patients 14 years of age or older).**

_____ _____

Patient/Parent/Guardian Signature Date