Patient Registration Form

Heart of Florida Health Center has partnered with your child's school to provide medical, behavioral, and dental care during school hours, ensuring they do not miss class. These services are also available at our community locations across Marion County. Billing will be processed through insurance, and if your child does not have insurance, a fee will be billed to you. Health assessments and exams will take place over four to six weeks, with potential follow-ups over 18 months for treatment, maintenance, and preventive care. All services are provided by licensed medical and dental professionals from Heart of Florida Health Center.

Section 1: Student/Patient Demographics

Last Name: _____
First Name: _____
Middle Name: _____

Date of Birth:
(MM/DD/YYYY): ____/____/_____
Sex: ☐ Male ☐ Female
Social Security #: _____

For Minors (18 years or less)
Parent/Guardian Full Name:
_____
Relationship: _____
Date of Birth (MM/DD/YYYY): ____/____/_____

Parent/Guardian Full Name:
_____
Relationship: _____
Date of Birth (MM/DD/YYYY): ____/____/_____

Address:
Street Address: _____
City: _____
State: _____
Zip Code: _____

Contact Information:
Home Phone: (____) _____
Cell Phone: (____) _____
Email:
_____

Emergency Contact: Full Name: _____ Contact #: (____) _____ Relationship with Patient: _____

More About your child

Race:
☐ White ☐ Black/African American ☐ Asian ☐ Native American ☐ Pacific Islander
☐ Other: _____ ☐ I choose not to disclose

Ethnicity:
☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Mexican American/Chicano/a ☐ Puerto Rican ☐ Cuban
☐ Other: _____ ☐ I choose not to disclose

Alternate Housing (if applicable):
☐ Homeless (outdoors/street) ☐ Homeless shelter ☐ Doubling up ☐ Transitional housing
☐ Permanent supportive housing

Language & Accessibility Needs:
Preferred Language: _____
☐ My Child will need a language interpreter for medical visits
☐ My Child is hearing impaired and will need sign language services

Medical Planning

Preferred Pharmacy:
If you wish to send prescriptions to HFHC Pharmacy, please choose:
☐ Silver Springs Blvd. ☐ Belleview ☐ South Pine – Drive Thru

Preferred Pharmacy Name and Address:
_____ _____

Section 2: Insurance Information (Copy of Insurance Card is Required)

Heart of Florida Health Center will bill your insurance for services covered based on their insurance plan. Parents/Guardians must provide accurate and up-to-date insurance information to avoid delays. If insurance details are not updated or coverage changes, it may affect proper billing.

☐ PATIENT HAS NO INSURANCE

	Primary	Secondary	Dental
Insurance Company:			
Employer:			
Policy Holder's Name:			
Policy Number:			
Policy Holder's Date of Birth:	____/____/_____	____/____/_____	____/____/_____
Relationship with Patient:	☐ Self ☐ Spouse/Partner ☐ Parent/ Guardian	☐ Self ☐ Spouse/Partner ☐ Parent/ Guardian	☐ Self ☐ Spouse/Partner ☐ Parent/ Guardian

Section 3: Income Attestation – Self-Declaration (Required for All patients)

1. **Household Size** (Number of people in the household, as defined by tax dependency rules)

   ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8+ (Specify: _____)

2. **Income Attestation** (Select the range that best represents your household's total income)

   ☐ $0 - $20,000
   ☐ $20,001 - $40,000
   ☐ $40,001 - $60,000
   ☐ $60,001 - $80,000
   ☐ $80,001 - $100,000
   ☐ $100,001 - $120,000
   ☐ $120,001 - $140,000
   ☐ Over $140,000

3. **Are you applying for the Sliding Fee Discount Program?**

   ☐ *Yes **(Complete Section #6)***
   ☐ *No: Please note:* By declining, I acknowledge that I am choosing to pay full fees for services received at Heart of Florida Health Centers Inc., including any fees not covered by my insurance. I agree to pay any balance in full.

Attestation Statement

*I certify that the information provided above is true to the best of my knowledge. I understand that this information may be subject to verification. I allow **Heart of Florida Health Center (HFHC)** to send bills and get payments from **Medicare, Medicaid, insurance, or other programs** that help pay for my medical care. I understand that if my insurance or program does not pay HFHC, I must pay for my care, including any copays, coinsurance, or deductibles. I agree to pay my bill on time.*

Print Name: _____ Relationship with Patient: ☐ Self ☐ Parent ☐ Legal Custodian ☐ Legal Guardian Date: ___/___/____

Signature: _____

Section 4: School-based supplemental health services consent form

By signing this form, you:

1) **Give permission** for your child to receive healthcare services at school from **Heart of Florida Health Center**, with or without a parent/guardian present.
2) **Understand that care may be in-person or by telehealth.** Telehealth may have limitations, such as no physical contact and possible connection issues. Your child can stop using telehealth at any time without affecting future care.
3) **Agree to be responsible** for any fees or charges not covered by insurance.
4) **Allow Heart of Florida Health Center** to share your child's health information with school health staff (nurses, therapists, social workers, dentists, etc.) to coordinate care.
5) **Allow the school's staff** to share your child's medical and personal information with Heart of Florida Health Center to help assess health needs, provide treatment, or refer for services.

- If you have questions about the services, risks, or alternatives, you can call **352-732-6599** before signing.
- Services may be provided **in person or by telehealth**.
- Signing this form means you **agree to the services and/or immunizations** listed below.

If there are any services or immunizations you do NOT want your child to receive, please check the boxes below.

Opt-Out of Services **Check any services you DO NOT want your child to receive:**	**Opt-Out of Immunizations** **Check any shots you DO NOT want your child to receive:**

☐ Physical Exams (Well-child, Sports, Work)
☐ Treatment for Illness or Injury
☐ Lab Tests
☐ Prescription Medications
☐ Care for Common Health Concerns (Weight, Acne, Menstrual Issues)
☐ Chronic Condition Management (Asthma, Seizures, Diabetes)
☐ Mental/Behavioral Health Services (*Parental consent required for children under 14*)
☐ Vision & Hearing Screenings
☐ Dental Services
  ☐ X-rays,
  ☐ Exams
  ☐ Sealants
  ☐ Fluoride
☐ Health Education & Prevention Programs
	School Required Immunizations:
	☐ DTap/Td
	☐ Tdap
	☐ Polio
	☐ Hepatitis B
	☐ MMR (Measles, Mumps, Rubella)
	☐ Meningococcal A
	☐ Varicella (Chickenpox)
	
	Pediatric/Adolescent Recommended Immunizations:
	☐ Human Papillomavirus (HPV)
	☐ Influenza (Flu)
	☐ Hepatitis A
	☐ Meningococcal B

I, Parent/Guardian, confirm that I am in good health and understand this consent form. I have read it and agreed with the information and give my permission for my child to receive the recommended health services or treatment.

Print Name: _____ Relationship with Patient: ☐ Self ☐ Parent ☐ Legal Custodian ☐ Legal Guardian Date: ___/___/_____

Signature: _____

Student School-Based Health Services Registration Form

Section 5: Patient Medical Information Form

Primary Care Physician Name: _____Last Visit Date: (MM/DD/YYYY) ____/____/_____

Primary Dentist Name: _____Last Visit Date: (MM/DD/YYYY) ____/____/_____

Please include Medication Name, Dose and Times per day Taken. *(vitamins, inhalers, prescriptions, other)*

Patient Current Medications _____

_____

_____

Patient Medical History

- ☐ Allergies or Skin Conditions (e.g., Eczema, Rashes) → List: _____
- ☐ Blood Disorders (e.g., Anemia, Sickle Cell) → List: _____
- ☐ Bone, Joint, or Muscle Conditions (e.g., Arthritis, Cerebral Palsy, Spine Issues) → List: _____
- ☐ Breathing Issues (e.g., Asthma, Chronic Cough, Pneumonia) → List: _____
- ☐ Cancer (e.g., Leukemia) → List Type: _____
- ☐ Dental Issues (e.g., Tooth Pain, Bleeding Gums, Jaw Problems - TMJ) → List: _____
- ☐ Developmental or Learning Conditions (e.g., Autism, ADHD, Delays) → List: _____
- ☐ Diabetes or Frequent Thirst
- ☐ Digestive or Liver Problems (e.g., Stomach Issues, Hepatitis) → List: _____
- ☐ Heart or Circulation Problems (e.g., Heart Disease, High Blood Pressure, Pacemaker) → List: _____
- ☐ History of Blood Transfusions
- ☐ Infectious Diseases (e.g., Tuberculosis, STDs) → List: _____
- ☐ Kidney or Urinary Issues (e.g., Frequent Infections, Kidney Disease) → List: _____
- ☐ Mental Health Concerns (e.g., Anxiety, Depression) → List: _____
- ☐ Premature Birth
- ☐ Reproductive Health Issues (e.g., Pregnancy, PCOS) → List: _____
- ☐ Seizures or Neurological Issues (e.g., Epilepsy, Stroke, Fainting, Dizziness) → List: _____
- ☐ Substance Use (e.g., Alcohol, Drugs) → List: _____
- ☐ Taking Bone Hardening Medications (Bisphosphonates)
- ☐ Thyroid Problems
- ☐ Tobacco or Vaping Use
- ☐ Vision or Hearing Issues (e.g., Glasses, Hearing Aids) → List: _____
- ☐ Weakened Immune System (e.g., HIV/AIDS, Organ Transplant) → List: _____

Other Health Concerns → Please Explain:

_____

Patient Allergies

Food/Insects/Animals/Seasonal Allergies	☐ Yes	☐ No	Specify: _____
Medication Allergies	☐ Yes	☐ No	Specify: _____
Latex Allergies	☐ Yes	☐ No	Specify: _____

Reaction to Immunizations ☐ Yes ☐ No If Yes, State which Vaccine and describe Reaction: _____

Past Hospital Stays	☐ Yes	☐ No	Explain: _____
Past Surgeries	☐ Yes	☐ No	Explain: _____
ER visits in past year	☐ Yes	☐ No	Reasons for Visits: _____

Family Medical History Check all that apply and list the affected relative(s) (e.g., Parent, Sibling, Grandparent).

☐ Anemia	☐ SIDS	☐ Migraines	**Affected Relative(s):**
☐ Stroke	☐ AIDS/HIV	☐ Arthritis	_____
☐ Heart Disease	☐ Sickle Cell	☐ Dental Issues	_____
☐ High Blood Pressure	☐ Asthma	☐ Alcohol/Drug Abuse	_____
☐ Diabetes	☐ Cancer	☐ High Cholesterol	_____
☐ Seizures	☐ Tuberculosis	☐ Other: _____	

Signature of Patient, Parent or Guardian: _____ **Date:** ___/___/_____

Provider Signature: _____ **Date:** ___/___/_____

Section 6: Sliding Fee Discount Application

(Complete this section **only** if applying for the Sliding Fee Discount Program.)

Proof of Income (Check all that apply.)	***Government-Issued Identification (Required for all applicants.)***
☐ *Wages and Federal Tax Statement (e.g., W-2)* ☐ *Recent Paystubs* ☐ *Determination or Benefits Verification Letter* ☐ *Self-Employment Ledger Documentation* ☐ *Employer Statement (Signed on company letterhead)* ☐ *Other: _____* ☐ ***No Proof of Income Provided (Complete Self-Declaration of No Income below)***	☐ *Driver's License* ☐ *Passport* ☐ *U.S. Immigration Form* ☐ *Other:* _____

Section 7: Declaration of No Income

Complete only if you selected "No Proof of Income Provided" above.)

1. **I confirm that I do not receive money from any of the following sources:**
   - *Wages from a job (including tips, bonuses, or commissions)*
   - *Money from my own business*
   - *Rent payments from property I own*
   - *Interest or dividends from savings or investments*
   - *Social Security, retirement, pension, or insurance payments*
   - *Unemployment or disability benefits*
   - *Government assistance (such as food stamps or cash aid)*
   - *Alimony, child support, or financial help from someone outside my household*
   - *Money from selling products (e.g., Avon, Mary Kay, etc.)*
   - *Other income*

2. **Certification of Financial Support**
   I confirm that I have no income right now and do not expect any changes soon. If my financial situation changes, I will inform Heart of Florida Health Centers Inc. My basic needs (housing, food, utilities) are covered by:

Name: _____ or **Agency (if applicable):** _____
Phone: _____ **Address:** _____

3. **Acknowledgment & Certification**
   I confirm that the information I provided is true and correct to the best of my knowledge. I understand that giving false, incomplete, or misleading information may result in losing assistance from **Heart of Florida Health Centers Inc.**

Print Name: _____ Relationship with Patient: ☐ Self ☐ Parent ☐ Legal Custodian ☐ Legal Guardian Date: ___/___/_____

Signature: _____