



P.O. Box 226 • 321 Mitchell Avenue
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Phone: 812.934.6624

SOUTH RIPLEY TELEHEALTH STUDENT INFORMATION

Student Information

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

Date of Birth: _____ Social Security Number: _____ Gender: Male Female

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

Home Phone: _____ Cell Phone: _____

E-mail Address: _____ Preferred Language: _____

Does your child have any special communication needs? Yes No If yes, explain: _____

Race: American Indian or Alaskan Native Asian Black or African American White Unknown

Other: _____ Patient Refuses

Ethnicity: Hispanic or Latino Not Hispanic or Latino Other: _____ Patient Refuses

Primary Care Provider: _____ Patient does not have a primary care provider.

Pharmacy of Choice: _____ City: _____ State: _____

Emergency Contact

In case of emergency, please provide a local friend or relative (not living at the same address) we may contact.

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

Date of Birth: _____ Relationship to Student: _____ Gender: Male Female

Home Phone: _____ Cell Phone: _____

Insurance Information - Guarantor Responsible for Bill

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

Date of Birth: _____ Relationship to Student: _____ Gender: Male Female

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

Home Phone: _____ Cell Phone: _____

Name of Primary Insurance Company: _____

Insurance ID #: _____ Group #: _____ Date of Birth: _____

Policy Holder Last Name: _____ First Name: _____ Middle Initial: _____

Employer: _____ Employment Status: _____

Patient's Relationship to Subscriber: _____

Name of Secondary Insurance Company: _____

Insurance ID #: _____ Group #: _____ Date of Birth: _____

Policy Holder Last Name: _____ First Name: _____ Middle Initial: _____

Employer: _____ Employment Status: _____

Patient's Relationship to Subscriber: _____

Medicaid ID #, if applicable: _____

Who does the child live with most of the time? _____

My child does not have health coverage. I would like a ClaimAid representative to contact me to assist with coverage options or to enroll in MMH's financial assistance program.

Mother/Guardian: _____ Phone Number: _____

Father/Guardian: _____ Phone Number: _____

Medication History

Does your child have any allergies to medications? Yes No If yes, explain: _____

Does your child take any regular medications (Over the counter or prescription)? Yes No

If yes, list dose and frequency: _____

Review of Systems

Any lung problems? Yes No If yes, explain: _____

Any heart problems? Yes No If yes, explain: _____

Any kidney/urinary/genital problems? Yes No If yes, explain: _____

Any bone/muscle problems? Yes No If yes, explain: _____

Any gastrointestinal problems? Yes No If yes, explain: _____

Any brain/nervous system problems? Yes No If yes, explain: _____

Any skin problems? Yes No If yes, explain: _____

Any eye/ear/nose/throat problems? Yes No If yes, explain: _____

Hospitalizations and Surgeries

Has your child been hospitalized? Yes No If yes, explain: _____

Has your child had any surgeries? Yes No If yes, explain: _____

Social History

Parents: Single Married Separated Divorced

List any siblings: _____

How many people currently live in your home? Adults: _____ Children: _____

Is your child currently enrolled in daycare? Yes No

Does your child participate in regular exercise? Yes No If yes, explain: _____

Does your child drink caffeine? Yes No

What is your water source? _____

Social History (Continued)

Has your child had chicken pox? Yes No If yes, when: _____

Has your child seen a sub-specialist? Yes No If yes, when: _____

Any developmental concerns or learning problems? Yes No If yes, explain: _____

Any behavioral problems or eating disorders? Yes No If yes, explain: _____

Any medical issues we should be aware of? Yes No If yes, explain: _____

If your child has a telehealth visit, a summary of the clinical visit will be available on Margaret Mary's Patient Portal.

Yes! I want to enroll in Margaret Mary's Patient Portal.

Parent/Guardian Signature: _____ Date: _____