NEVADA HEALTH CENTERS

Nevada Health Centers, Inc.
NEVADA CHILDREN'S HEALTH PROJECT
PATIENT DEMOGRAPHICS

(All information is strictly confidential)

SECTION A: Patient Demographics

Last Name	First	Middle Initial	Birth Date: / /
Street Address	Apt #	City	State Zip
Mailing Address / P.O. Box	Apt #	City	State Zip
Home Phone ( )	Cell Number ( )	Primary Language: _____ Ethnicity: ☐ Hispanic ☐ Non Hispanic	
E-mail Address:			

Birth Sex:	Gender Identity:	Sexual Orientation:	Preferred Pronoun(s):
☐ Male	☐ Male	☐ Lesbian or gay	☐ He, Him, His
☐ Female	☐ Female	☐ Straight (not lesbian or gay)	☐ She, Her, Hers
Current Gender:	☐ Transgender Male / Female-to-Male	☐ Bisexual	☐ They, Them, Theirs
☐ Male	☐ Transgender Female / Male-to-Female	☐ Something else	☐ Ze, Hir
☐ Female	☐ Other	☐ Don't know	☐ Decline to Answer
☐ Undifferentiated	☐ Chose not to disclose	☐ Chose not to disclose	☐ Other

Which of the following groups do you feel you belong to? ☐ American Indian/Alaska Native ☐ Black/African American ☐ White ☐ Asian ☐ Pacific Islander ☐ Native Hawaiian ☐ Refused to report

Name of Primary Care Physician

SECTION B: YES, I have Medical Insurance

Insurance Information (Guarantor)

Insurance Holder's Name as it appears on the insurance card		Date of Birth of Insurance Holder
Insurance Holder's Employer and Address		
Insurance Plan Name	Subscriber ID	Group Name/Number
Insurance Company Address		

SECTION C: NO, I do not have Medical Insurance

A Financial Counselor will be in contact to provide assistance in your child's care, please provide the following information:

Name	Phone Number ( )

SECTION D: Emergency Contact Information

Name			
Street Address	Apt #	City	State Zip
Home Phone ( )	Cell Phone ( )	Work Phone ( )	Relationship to Patient

NEVADA HEALTH CENTERS

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PATIENT PARENTAL / COURT-APPOINTED GUARDIAN NOTICE

HIGHLIGHTED AREAS MUST BE COMPLETED FOR SCHEDULING AND REGISTRATION

Please read carefully and complete the following statement acknowledging that your son/daughter/ward may receive services at the Nevada Children's Health Project Medical Mobile Unit.

Patient Name:	DOB:

I acknowledge that my son/daughter/ward named above may receive the following services at Nevada Children's Health Project Medical Mobile Unit:

- Comprehensive health inquiry
- Physical examinations (general, sports, pre-employment)
- Diagnosis and treatment for minor illnesses and injuries
- Screening for select health problems (vision screening, hypertension, etc.)
- Care of certain chronic conditions such as asthma and seizure disorders
- Immunizations as needed (tetanus, measles/mumps, rubella, etc.)
- Individual health and wellness education services
- Routine lab tests
- Prescription medications
- Care for common pediatric/adolescent physical concerns (weight, acne, menstrual problems, etc.)
- Pregnancy testing
- Birth control management
- Diagnosis and treatment of sexually transmitted diseases
- Mental health assessments
- Follow-up care as needed

Financial Responsibility: If you have insurance, Nevada Health Centers will bill your insurance company. Any copays will be billed. If you are uninsured, a Nevada Health Centers financial counselor will be contacting you to explore possible assistance options.

After Visit Summary: If your child/ward receives services in the Nevada Children's Health Project Medical Mobile Unit, you/your child will receive an After Visit Summary in a sealed envelope.

Prescriptions: All prescriptions will be electronically prescribed and sent to your preferred pharmacy identified in the Nevada Children's Health Project History Form.

I certify that I have read this notice and understand its contents.

_____ _____

Parent / Legal Guardian Signature (*Patient can sign if patient is 18 years or older*) Date

_____

Relationship to Patient

NEVADA HEALTH CENTERS

Nevada Health Centers, Inc.
NEVADA CHILDREN'S HEALTH PROJECT HISTORY FORM

(All information is strictly confidential)

Patient Name: _____ DOB: _____

Please check ☒ all that apply:

ALLERGIES	
☐ YES, please list below	☐ NO KNOWN ALLERGIES
☐ Food:	
☐ Medications:	
☐ Insects:	
☐ Seasonal:	
☐ Animals:	

PAST MEDICAL HISTORY	
☐ Allergies	☐ Heart disease
☐ Asthma	☐ Neurological
☐ Developmental	☐ Behavioral, please list:
☐ Diabetes	
☐ Ear infections	☐ Other, please list:
☐ Gastrointestinal	

CURRENT MEDICATIONS			
Name of Medication	**Dose**	**Amount taken**	**Times per day**

PREFERRED RETAIL PHARMACY	
Name:	Phone Number:
Address:	

Please check ☒ all that apply:

FAMILY HISTORY	MOTHER	FATHER	SISTER	BROTHER	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	OTHER, PLEASE LIST
Alcohol / drug abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cancer, type: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐
Developmental problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gastrointestinal	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Prostate cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐	☐	☐	☐	☐	☐

_____ _____

Parent / Legal Guardian Signature (*Patient can sign if patient is 18 years or older*) Date