Memorial Hermann Health System
Health Centers for Schools
PATIENT REGISTRATION

Date completed: _____

Name: (Last) _____ (First) _____ (Middle) _____

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

Birth Date: _____ Birth Gender: ☐ Male ☐ Female ☐ Other: _____

School: _____ Grade: _____ Student ID#: _____

Primary language spoken at home: _____ _____

Race: ☐ Asian/Pacific Islander ☐ African American ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other: _____

HEALTH INSURANCE INFORMATION.

Primary Insurance: ☐ Medicaid ☐ CHIP ☐ Private Insurance ☐ Harris Health (Gold Card) ☐ No Insurance

If Medicaid/CHIP, Policy #: _____ Plan Name: _____

If Private Insurance, Plan Name: _____

Does your child qualify for free or reduced lunch at school? ☐ YES ☐ NO

When was your child's last well exam or check-up? _____

PERSON RESPONSIBLE FOR THE PATIENT.

Relationship: _____ E-mail: _____

Name: (Last) _____ (First) _____ (Middle) _____

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

Day Phone #: _____ Alternate Day Phone #: _____

EMERGENCY CONTACT INFORMATION (To be contacted if parent/guardian cannot be reached).

Relationship: _____ E-mail: _____

Name: (Last) _____ (First) _____ (Middle) _____

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

Day Phone #: _____ Alternate Day Phone #: _____

By electronically signing this document, I acknowledge that, for all purposes herein, my electronic signature shall be deemed the same as my original signature. As the parent/legal guardian and having authority to sign the above document, I acknowledge that I have read the document, the information provided is accurate to the best of my knowledge, and any questions I have, have been answered to my satisfaction.

☐ AM
☐ PM

Parent / Guardian Signature	Print Name	Relationship to patient	Date	Time

MEMORIAL HERMANN

Health Centers for Schools Patient Registration Form

17082 (6/21)

ORIGINAL