MARGARET MARY HEALTH

P.O. Box 226 • 321 Mitchell Avenue
Batesville, IN 47006
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: _____

Medical History

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: _____