



Student General Information

First Name:	Middle Initial:	Last Name:	
Student's Address:	City:	State:	Zip:
Birthdate:			
Name of Student's Pharmacy:		Phone Number:	

Parent/Guardian Information

Mother/Guardian:	DOB:	Cell Phone:	
Email:	What is the <u>best way</u> to reach you: <input type="checkbox"/> Cell phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Text <input type="checkbox"/> Email		
Can we text appointment reminders: <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you authorize our staff to leave a voicemail regarding treatment, test results or other necessary information (excluding confidential services)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Father/Guardian:	DOB:	Cell Phone:	
Email:	What is the <u>best way</u> to reach you: <input type="checkbox"/> Cell phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Text <input type="checkbox"/> Email		
Can we text appointment reminders: <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you authorize our staff to leave a voicemail regarding treatment, test results or other necessary information (excluding confidential services)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Parent/Guardian Address:	City:	State:	Zip:

Emergency Contact (Non-Household Member): Relationship: Phone #:

FQHC-Required Demographic Information

It is the policy of NMHSI to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

Race: White Asian Black/African American Native Hawaiian Pacific Islander Other: _____

Native American/Alaska Native- Tribal Member: Yes No Descendent: Yes No Name of Tribe: _____

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Other: _____ Preferred Language: _____

Are you a veteran? Yes No Are you homeless? Yes No Do you need an Interpreter: Yes No

Do you work in Agriculture? Migrant Worker Seasonal Worker None

This Section to be Completed for Patients 18 Years of Age and Over

Sexual Orientation: Straight Bisexual Lesbian/Gay Something Else Don't Know Choose not to Disclose

Gender Identity: Male Female Transgender Male (F→M) Transgender Female (M→F) Choose not to disclose Other

Income Information & Health Insurance Information (we will bill your insurance for services)

*Federal Regulations require that we report the **combined total** of all household members' income for those seeking care at NMHSI. We ask your cooperation in indicating the following:

Total Number in Household: _____ Your yearly combined household income is: \$ _____

Even if the student has insurance, the student may qualify for NMHSI's sliding fee scale, which offers discounted fees for services.

Do you want to apply to see your qualifications? No Yes

Does the student currently have health insurance? Uninsured Medicaid Private

Policyholder's Name: _____ DOB: _____

Insurance Carrier: _____ Policy #: _____ Group #: _____

Signature of Parent/Guardian/Patient aged 18 and older

Print Name

Date