The Health Center at Port Angeles High School
Health Services Registration

Student's Information

First Name ______________________

Last Name ______________________

Date of Birth ____________ Grade in School ______

Student's Identifying Gender ______________

Phone #: Cell __________ Home __________

Address ______________________

City ____________ State ______ Zip ___

Parent/Guardian's Information

First Name ______________________

Last Name ______________________

Relationship to Student ______________

Phone #: Cell __________ Home __________

Address ______________________

City ____________ State ______ Zip ______

Check all that describe student's ethnicity:

_____ Black/African American

_____ Asian

_____ American Indian/Alaskan Native

_____ Hispanic

_____ Pacific Islander

_____ White

_____ Other: ______________________

Student's Emergency Contact

Name ______________________

Phone #: Cell __________ Home __________

Relationship to Student ______________

Student lives with: please check all that apply

____ Mother ____ Father ___ Legal Guardian

____ Stepmother ___ Stepfather ___ Grandparent(s)

_____ Alternates Bet. Parents _____ Foster Parent(s)

_____ Emancipated Minor ___ Other: __________

Insurance information

Does student have health insurance? __Yes __No

Insurance Plan Name: ______________________

Policy Number ______________________

Group Number ______________________

Subscriber Name: ______________________

Subscriber Date of Birth: ______________________

Subscriber's relationship to student: __________

Fees and Billing

No one will be denied service due to inability to pay, but the following information is required so we can bill your insurance or determine if you qualify for a sliding fee discount. If you do not wish to provide the information we will bill you at full fee for service.

Sliding Fee Program: If the student does not have insurance and does not qualify for Apple Health we can provide sliding fees for certain services.
Please Complete:

Your Gross Monthly Household Income:$ __________

Number of Family Members in Your Household: ____

Please turn over and complete the Consent Form on the other side →

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