106 E. Broad Street
P.O. Box 2024
Savannah, Georgia 31402
(912) 527-1000

349 West Bryan Street
Savannah, Georgia 31401
(912) 527-2727

CURTIS V. COOPER PRIMARY HEALTHCARE, INC.

5354 Reynolds Street, Suite 420
Savannah, Georgia 31405
(912) 355-6990

2 Roberts Street
Savannah, Georgia 31405
(912) 527-1100

800 East 70th Street
Savannah, Georgia 31405
(912) 790-6500

Dear Parent/Guardian,

Curtis V. Cooper Primary Healthcare, Inc. (CVCPHC) has joined in collaboration with Savannah-Chatham County Public Schools to improve health care accessibility for your child.

Your child's school has been selected to participate in a School Based Initiative in which your child may receive certain health care services at no cost to you. Reimbursement from third party payers will be billed accordingly. Health Teams consisting of physicians, dentists, advanced registered nurse practitioners, registered nurses, license practical nurses, and licensed social workers will provide the traditional school health services. These traditional services routinely provided include, rendering first aid, medication administration, provision of classroom lectures and activities, as well as counseling/behavioral health. By enrolling your child into the School Based Initiative, he/she will also be eligible to receive physical examinations (sports physicals), blood and urine tests, oral health services, and vaccinations as warranted. These designated health care services will be provided at your child's school.

To enroll your child, you must complete a CVCPHC application and a general consent form. The application and consent form enables your child to receive services at all CVCPC locations. All students are eligible. After the forms are received, a registration staff member will contact you by phone for additional information to complete the registration process. Please contact your school administrator with any questions you may have.

It is our goal to contribute to the physical, mental, and social well-being of each student.

Sincerely,

Albert B. Grandy, Jr.
Chief Executive Officer

Fariborz A. Zaer, M.D.
Chief Medical Officer

CURTIS V. COOPER PRIMARY HEALTH CARE, INC.

Registration and Financial Evaluation Records
(Savannah Chatham County School System use only)

Patient Information

Date of Registration / Time	Last Name	First Name	Middle Name	Account Number
	Date of Birth	Age	Birth Sex	Slide Fee Scale/Review Date
Preferred Pharmacy?	Do you have an Advance Directive or a living will? Y N			Household Size #
Address/Apartment #		City, State, Zip		
Phone:	Work Phone:	Work Status	Employer Name	
Patient Email Address		Marital Status	Highest Level of Education	

Demographic Information

Patient Gender:		Do you think of yourself as:	
o Male	o Transgender Male / Female-to-Male	o Straight	o Gay
o Female	o Transgender Female / Male-to-Female	o Lesbian	o Bisexual
o Other o Declined	o Gender queer: Neither Exclusively Male nor Female	o Other o Declined	o Unknown

Guarantor Information

Last Name	First Name	Relationship to Patient	Date of Birth
Email Address	Sex	Phone:	
Address/Apartment #		City, State, Zip	

Insurance Information

Primary Insurance Plan Name	Primary Policy # / Group #	Primary Subscriber Name/ DOB
Secondary Insurance Plan Name	Secondary Policy # / Group #	Secondary Subscriber Name/ DOB

Emergency Contact Information

Last Name	First Name	Middle Name
Relationship to Patient	Home Phone	Work Phone
Preferred Language:	**What is your race?** □ □ American Indian or Alaska Native □ □ Asian □ □ Black or African American □ □ Native Hawaiian or Other Pacific Islander □ □ White □ □ Other **What is your ethnicity?** □ □ Hispanic or Latino or Spanish Origin □ □ Not Hispanic or Latino or Spanish Origin	**Additional Information:** Homeless Y N Worker Status: Migrant/Seasonal Worker Y N Public Housing Y N Veteran Y N Disabled Y N Please specify disability:

Patient Signature _____ **CVCPHC Employee** _____

Date: _____ **Date:** _____

Rev.08/22 S Miller

CURTIS V. COOPER PRIMARY HEALTHCARE, INC.

GENERAL CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION FOR INSURANCE PAYMENT

1. I, the undersigned or legal guardian, grant permission as indicated below to undergo all necessary tests, treatments, and other procedures or studies required for the diagnosis by the medical staff and other employees of Curtis V. Cooper Primary Healthcare, Inc.

2. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment and examination by Curtis V. Cooper Primary Healthcare, Inc.

3. I consent to the release of medical information to other institutions or agencies accepting the patient for medical or institutional care, and consent to the release of medical information to patient's insurer and give permission to release data (both medical and personal) to such government agencies as is required of Curtis V. Cooper Primary Healthcare, Inc. by law, rules, regulations, or by consent.

4. I consent to the release of medical and financial information for auditing purposes.

5. I consent for my medical records to be shared electronically, securely, and confidentially through Chatham Health Link Exchange, HIE. I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

6. I hereby authorize payment to Curtis V. Cooper Primary Healthcare, Inc. of benefits due to me in my pending claim and/or MAJOR MEDICAL BENEFITS, otherwise payable to me, but not to exceed the health center and/or physician regular charges for this period of treatment. I agree that a copy of this authorization is as valid as the original. I understand that if my insurance does not approve the charges for this visit, I am fully responsible to Curtis V. Cooper Primary Healthcare, Inc. for payment.

7. MEDICARE PATIENTS ONLY: I authorize any holder of medical or other information about me to release to Centers for Medicare and Medicaid (CMS) or its intermediaries or carriers, any information needed for this or any subsequent Medicare claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party that accepts assignment for such claim.

8. I hereby voluntarily consent to treatment now and during all subsequent visits to the Curtis V. Cooper Primary Health Care, Inc. I apply for and voluntarily consent to such primary care, mental health, family planning services, including HIVHCV testing, as may be ordered and/or recommended by physicians and/or appropriate designee responsible for my medical care. I further understand that if my healthcare providers recommend HIV/HCV testing as part of my medical treatment and/or care, I will have the opportunity to consent or4 refuse such testing at the time f the recommendation of HIV/HCV testing is discussed with me.

BY SIGNING THIS DOCUMENT, I ATTEST THAT ALL INFORMATION IS TRUE AND CORRECT AND I WILL NOTIFY CURTIS V. COOPER PRIMARY HEALTHCARE, INC. OF ANY CHANGES TO MY INSURANCE, INCOME, OR CONTACT INFORMATION.

Name of Patient (PLEASE PRINT)	CVCPHC Representative (PLEASE PRINT)
Signature of Patient or Legal Guardian	CVCPHC Representative's Signature

CURTIS V. COOPER PRIMARY HEALTHCARE, INC.
Medical History

Location: _____

NAME: _____ DATE: _____

Allergies_____

Primary Care Provider/Pediatrician: _____

Childhood Diseases: _____

_____

Illnesses: _____

_____

Hospitalizations: _____

Injuries: _____

_____

Present Medications (Name and Dosage):

_____

_____

Present Concerns: _____

_____

Social/Family Structure: Married _____ Single _____ Number of people in house _____

List: _____

Primary Caregiver: _____

Environmental:

Smokers: _____ Animals: _____

Safety Concerns: _____ Guns: _____

School Concerns: _____

DENTAL: Name of Dentist: _____ Date of last exam: _____

FAMILY HISTORY: Self, Mother, Father, Sister, Brother, Grandmother, Grandfather, Aunt, Uncle

	NO	YES	WHO		NO	YES	WHO
Allergies				Glaucoma			
Birth Defects				Asthma			
Cancer				Kidney Disease			
TB				Arthritis			
Diabetes				Gout			
Hypertension				Sickle Cell			
Heart Trouble				Psychiatric Problems			
Stroke				Hearing Loss			
Seizures				Substance Abuse			

Welcome to Curtis Cooper Primary Health Care ---Dental Dept
Patient Information (Please Print)

First Name _____ MI _____ Last Name _____ M/F _____ Date of Birth _____ Age _____

Street Address _____ City _____ State _____ Zip _____ Phone # _____

Patient Health History (Please Answer all Questions)

Heart Trouble	Y/N	Anemia	Y/N	Ulcers	Y/N
Tuberculosis	Y/N	Pregnant	Y/N	Diabetes	Y/N
HIV/AIDS	Y/N	Bleeding	Y/N	Epilepsy	Y/N
Hepatitis	Y/N	Allergies	Y/N		
Asthma/Breathing Problems	Y/N	Use of Diet Pills/Aids	Y/N	Disabilities	Y/N
Alcohol/Drug Abuse	Y/N	Rheumatic Fever	Y/N	Prosthetic joints, Plates or Pins	Y/N
Sickle Cell Anemia	Y/N	**ADHD** (Attention Deficit Hyperactivity Disorder)	Y/N	Heart Murmur	Y/N

Does child have any other Health Problems not listed: Y/N
If you answered "yes" to any of the above, please explain: _____

Is the patient taking any medications at this time (including over-the-counter medications such as aspirin) Y/N If "Yes", what type: _____

Is the patient allergic to any other materials commonly used in the dental office (I.e. latex gloves, anesthesia, etc.) Y/N If "Yes", what: _____

Does the patient have any dental problems/concerns at this time? Please explain: _____

Parent/Guardian Information (Please Print)

Mother/Guardian _____ Father/Guardian _____

Relationship to Patient _____ Phone Number _____

I certify that I have read and understand the above. I will not hold the dentist, or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Parent/Guardian _____ Date _____

Dentist _____ Date _____