SUPPLEMENTAL CHILD'S REGISTRATION FORM

Patient Information

Last Name | First Name | Middle Initial

Date of Birth | Social Security Number

Address (if different than Registration form)

Financial Responsibility ❒ Parent ❒ Legal Custodian ❒ Guardian/Power of Attorney

Last Name | First Name

Address | City | State | Zip

Date of Birth | Social Security Number | Home Phone

Insurance Information

Primary Medical Insurance Company:

Plan ID Number | Plan Group Number

Name of Policy Holder | Policy Holder's Date of Birth | Policy Holder's Social Security Number

Secondary Medical Insurance Company:

Plan ID Number | Plan Group Number

Name of Policy Holder | Policy Holder's Date of Birth | Policy Holder's Social Security Number

Primary Dental Insurance Company:

Plan ID Number | Plan Group Number

Name of Policy Holder | Policy Holder's Date of Birth | Policy Holder's Social Security Number

Additional Patient Information

Race: ❒ Asian ❒ White ❒ Black or African American ❒ American Indian or Alaskan Native ❒ Other race ❒ Pacific Islander ❒ Unreported/refused to report **Preferred Language:** _____

Ethnicity: ❒ Hispanic or Latin American ❒ Non-Hispanic ❒ Unreported/refused to report

Veteran Status: Have you ever been in the Armed Forces of the United States? ❒ Yes ❒ No

Residence: How many people are living in your home, including yourself? _____

What is the estimated total annual household income, including government assistance and disability?

❒ Under $11,000 ❒ $15,001- $20,000 ❒ $25,001- $35,000 ❒ $45,001- $55,000

❒ $11,001- $15,000 ❒ $20,001- $25,000 ❒ $35,001- $45,000 ❒ Over $55,000

Are you a seasonal resident? ❒ Yes ❒ No Are you a migrant worker? ❒ Yes ❒ No

Do you live in public housing? ❒ Yes ❒ No Are you homeless? ❒ Yes ❒ No

Are you living in a multi-family home? ❒ Yes ❒ No

The following people are authorized to present the patient listed above for appointments and receive information regarding their medical and dental care:

Person 1: **Person 2:**

Parent/Guardian Signature | Date