ATTACHMENT II

BAKER COUNTY HEALTH DEPARTMENT
DENTAL PATIENT REGISTRATION

NOTE: THIS FORM IS REQUIRED BEFORE YOUR CHILD CAN BE TREATED!

PLEASE PRINT

PATIENT NAME
FIRST: _____ **M. INITIAL:** _____ **LAST:** _____

ADDRESS: _____ **CITY:** _____ **ZIP:** _____

DRIVING DIRECTIONS: _____

PHONE NUMBER: _____ **SCHOOL:** _____ **GRADE:** _____

PATIENT'S SOCIAL SECURITY NUMBER: _____ **RACE:** _____ **SEX:** _____

PATIENT ON MEDICAID (Y OR N): _____ **MEDICAID #** _____

NAME OF PERSON EMPLOYED: _____ **EMPLOYER:** _____

MONTHLY INCOME: _____

SS: _____ **AFDC:** _____ **ALIMONY:** _____ **CHILD SUPPORT:** _____

UNEMPLOYMENT: _____ **WORKERS COMP:** _____ **OTHER UNEARNED INCOME:** _____

PLEASE LIST EVERYONE THAT LIVES IN THE HOUSEHOLD:

NAME	DOB	SSN	RACE/SEX	RELATIONSHI PATIENT
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____