

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:

| | <u>NAME</u> | <u>DOB</u> | <u>SSN</u> | <u>RACE/SEX</u> | <u>RELATIONSHIP PATIENT</u> |
|----|-------------|------------|------------|-----------------|---------------------------------|
| 1. | _____ | _____ | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ | _____ | _____ |
| 6. | _____ | _____ | _____ | _____ | _____ |
| 7. | _____ | _____ | _____ | _____ | _____ |
| 8. | _____ | _____ | _____ | _____ | _____ |

PARENT/GUARDIAN SIGNATURE

DATE