[redacted]

Demographics

Race:

- ☐ Asian Indian
- ☐ Filipino
- ☐ Koren
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Guamanian or Chamorro
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ More than one race
- ☐ Unreported/Chose Not to Disclose
- ☐ Chinese
- ☐ Japanese
- ☐ Vietnamese
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ White

Ethnicity:

- ☐ Mexican/Mexican American/Chicano
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Another Hispanic/Latino(a)/Spanish Origin
- ☐ Hispanic/Latino(a)/Spanish Origin/Combined
- ☐ Non-Hispanic/Latino(a)
- ☐ Unreported/Chose Not to Disclose

_____

*note **self** if student lives independently

Student Phone Number: _____ **Student Email Address:** _____			**Student Birth Sex**: ☐ Female ☐ Male ☐ Other ☐ Undefined **Student Social Security Number:** _____		
Parent / Guardian Name:			**Insurance Subscriber Name:**		
Date of Birth: ____/____/___	Sex: ☐ Female ☐ Male	SSN: ___-___-_____	Date of Birth: ____/____/_____	Sex: ☐ Female ☐ Male	SSN: ___-___-_____
Address:			Insurance Company Name: Address:		
City:	State:	Zip:	City:	State:	Zip:
Home Phone:	Cell Phone:		Phone:	Effective Date:	
E-Mail Address:	Employer Name:		Policy Number:	Group Number:	
Emergency Contact 1:	Relationship:		Guarantor Name:	Relationship to Patient:	
Do you have a medical provider? ☐ Yes ☐ No			Medical Provider Name:		
Do you have a dental provider? ☐ Yes ☐ No			Dental Provider Name:		

Is there a CUSTODY agreement in place? ☐ Yes ☐ No **If so, list primary custodian:**
Check this box if your child has no insurance coverage or insurance deductibles/co-pays**.**
Person Responsible for Payment: ☐ Mother ☐ Father ☐ Guardian or Other: _____
Preferred Method of Communication: ☐ Postal Mail ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Text ☐ Web Message

Permission to Communicate

School Based Health Center Sliding Scale Application

Student Name: _____ Student's Date of Birth: _____
Last First Middle (mm/dd/yyyy)