[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:** _____<br>**Student Email Address:** _____ | | | **Student Birth Sex**: ☐ Female ☐ Male ☐ Other ☐ Undefined<br>**Student Social Security Number:** _____ | | |
| **Parent / Guardian Name:** | | | **Insurance Subscriber Name:** | | |
| Date of Birth:<br>____/____/___ | Sex:<br>☐ Female<br>☐ Male | SSN:<br>___-___-_____ | Date of Birth:<br>____/____/_____ | Sex:<br>☐ Female<br>☐ Male | SSN:<br>___-___-_____ |
| Address: | | | Insurance Company Name:<br>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)