SOS MEDICAL & DENTAL CLINIC

Patient Registration Form – Pediatric

Patient Name: _____
Last First Middle

Does the patient have a **Social Security Number**? ☐ Yes ☐ No Social Security Number: _____

Date of birth: _____ Age: _____ Sex at birth: ☐ Male ☐ Female
Month / Day / Year

Patient's gender identity: ☐ Male ☐ Female ☐ Transgender Male/Female to Male ☐ Transgender Female/Male to Female ☐ Other ☐ Choose not to disclose

Patient's sexual orientation: ☐ Straight or heterosexual ☐ Lesbian, gay or homosexual ☐ Bisexual ☐ Something else/Other ☐ Don't know ☐ Choose not to disclose

Name of patient's: _____
Mother/Legal Guardian

_____
Father/Legal Guardian

Address: _____
Street Apt. # City Zip

Phone #: ( ) _____ ( ) _____ ( ) _____
Home Work Cellular

Family Living Situation: ☐ Own ☐ Rent ☐ Motel/Hotel ☐ Car/Vehicle ☐ Halfway House/Shelter ☐ Homeless Shelter
☐ Transitional ☐ Street ☐ Staying with friends/family - not paying rent ☐ Permanent Supportive Housing ☐ Other

Is patient disabled? ☐ Yes ☐ No **Anyone in the home smoke?** ☐ Yes ☐ No **A female head of household?** ☐ Yes ☐ No

Education level completed:
☐ not applicable ☐ middle school
☐ pre-school ☐ some high school
☐ elementary school ☐ high school graduate

Anyone in the home a:
Migrant Farm Worker?: ☐ Yes ☐ No
Seasonal Farm Worker?: ☐ Yes ☐ No

Race:
☐ American Indian / Alaska Native ☐ White (this includes Latino/Hispanic) ☐ Black/African American
☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ More than one race ☐ Refuse to Report

Patient Ethnicity:
☐ Non-Latino / Hispanic
☐ Latino/Hispanic
☐ Refuse to Report

What language should your information be provided in? _____

Emergency Contact: _____ ( ) _____
Name Relationship Telephone #

How did you hear of the S.O.S. Clinic? _____

1. Does the patient have health insurance? ☐ Yes ☐ No If YES, with what company are you insured? _____
2. Does the patient have dental insurance? ☐ Yes ☐ No If YES, with what company are you insured? _____
3. Does the patient have Medi-Cal? ☐ Yes ☐ No Have you applied? ☐ Yes ☐ No Policy Number? _____

I understand that my medical/dental information is confidential. I authorize the exchange of information between SOS and any other providers or organizations only as necessary for treatment, payment or health care operations purposes. Patient rights and confidentiality policies are posted in our waiting room and copies are available on request.

I hereby authorize treatment at Share Our Selves to provide treatment for (name of minor) _____

☐ Yes ☐ No Parent/Guardian Initials _____

Email address: _____
☐ I don't have an email or I would like to OPT OUT of interactive electronic communication with my Care Team at this time.

Adequate numbers of x-rays are required for proper diagnosis. I consent to performing x-rays as needed for patient's dental treatment:

☐ Yes ☐ No Parent/Guardian Initials_____

Parent or Legal Guardian Signature: **Date:**