

# Fordland Clinic: Child Information and Consent Form

Name \_\_\_\_\_ Soc Sec# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
County \_\_\_\_\_ Age \_\_\_\_ Sex M / F Phone # \_\_\_\_\_  
Guardian Phone # \_\_\_\_\_ Cell # \_\_\_\_\_ E-Mail \_\_\_\_\_

I **do not** want to be contacted by email for:  General health information including the quarterly newsletter  
 Specific medical info about my health condition(s)  Direct contact with my provider  Fundraising

Please indicate if child is:  Homeless Is child disabled?  Yes  No

Race:  White  Black/African American  Asian  American Indian/Alaskan Native  Native Hawaiian  Other Pacific Islander  Unknown

Are you of Hispanic/Latino origin?  Yes  No Current Student?  Yes  No

I prefer to receive information in a language other than English  Language \_\_\_\_\_

How did you hear about our clinic?

friend/family  newspaper (please list) \_\_\_\_\_  website  
 yellow pages  sign in front of clinic  billboard east (coming from Rogersville)  billboard west (coming from Seymour)  other \_\_\_\_\_

**Father's Name** \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Phone \_\_\_\_\_

Name of Insurance \_\_\_\_\_ Policy# \_\_\_\_\_

Group # \_\_\_\_\_

**Mother's Name** \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Phone \_\_\_\_\_

Name of Insurance \_\_\_\_\_ Policy# \_\_\_\_\_

Group # \_\_\_\_\_

Do both parents live with the patient? \_\_\_\_\_ If not, who has legal custody? \_\_\_\_\_

Please describe custody agreement: \_\_\_\_\_

Family Size \_\_\_\_\_ Annual Family Income (please circle) Less than \$10,000  
\$10,001 to \$25,000  
\$25,001 to \$40,000  
\$40,001 to \$55,000  
\$55,001 to \$70,000  
Greater than \$70,000

*Why are we asking for so much information? Fordland Clinic is a not-for-profit community health center, and as a non-profit, we can apply for grants to expand services. Many grant organizations request we provide demographic information about the patients we serve. Your privacy is important to us, we do not share your personal information or identity with third parties or advertising agents.*

**RESPONSIBLE PARTY/EMPLOYER INFORMATION/INSURANCE CARRIER**  
(Please give all insurance cards to the receptionist)

