CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM
PRE-ENROLLMENT APPLICATION

Instructions to the Parent or Patient:

- In order to receive a health examination today at no charge, you must provide the information required on this form. The information you give is confidential. This is a voluntary program.

  Is the patient less than 19 years of age? ☐ Yes ☐ No

  How many people are in your family? _____

  How much money does your family make before taxes? $_____ (Monthly) Or $_____ (Yearly)

- You or your child may be eligible for continued health care coverage through Medi-Cal or Healthy Families.

  I want to apply for continuing coverage through Medi-Cal or Healthy Families. ☐ Yes ☐ No

  If you answered *yes* to this question, an application will be mailed to you in a few days. Please return it promptly. If you answered *no* to this question (or if you answered *yes* but do not return the application), the patient's coverage for health, dental, and vision benefits will stop at the end of next month unless the county Department of Social Services notifies you otherwise.

Patient Information

Does the patient have a State of California Benefits Identification Card (BIC) or Medi-Cal card? ☐ Yes ☐ No

If yes, what is the identification number on the BIC card (if available)? _____

Patient's name—Last	First	Middle initial

Date of birth (month/day/year)	Gender ☐ Male ☐ Female	Patient's social security number (SSN) ***(optional)***

☐ If you are homeless, check here. Enter the general location in the "Home address" section and complete the "Mailing address" section.

Home address	Apartment number	City	State	ZIP code

County of residence

Mailing address (if different from home address)	Apartment number	City	State	ZIP code

Mother's name—Last	First	Middle initial

For patients under one year of age, please complete this section.

Mother's date of birth (month/day/year)	Mother's BIC or Medi-Cal card number or social security number

Parent/Legal Guardian Information

Name of parent/legal guardian or emancipated minor patient—Last	First	Middle initial

Home telephone number	Work telephone number	Message telephone number
( )	( )	( )

What language do you speak at home?	What language do you read best?

Certification

I am requesting a CHDP health examination today. I certify that I have read and understand this form. I declare that the information I have provided is true, correct, and complete.

Signature of parent/guardian or emancipated minor	Relationship to patient	Date

An individual has a right to review records containing his/her personal information. The official entity responsible for keeping the information is the Department of Health Care Services, MS 8100, P.O. Box 997413, Sacramento, CA 95899-7413. A copy of this information may be shared with the county Department of Social Services in the county in which you reside and will be kept with your child's medical record by your child's CHDP provider.

HCA/Public Health Services
Family Health Clinic

CHILD HEALTH REGISTRATION FORM

ADDITIONAL PATIENT INFORMATION

1. Patient's Place of Birth: _____

2. Ethnic Group (circle one only)

- ☐ Aleut
- ☐ Algerian
- ☐ Native American/American Indian
- ☐ Amerasian
- ☐ Bangladeshi
- ☐ Black/African American
- ☐ Cambodian
- ☐ Caucasian/European/White
- ☐ Chinese
- ☐ Cuban
- ☐ Egyptian
- ☐ Eskimo
- ☐ Filipino
- ☐ Guamanian
- ☐ Hawaiian Native
- ☐ Indian (Asian)
- ☐ Iranian
- ☐ Iraqi
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Lebanese
- ☐ Mexican
- ☐ Other Asian-Specified
- ☐ Other Asian-Unspecified
- ☐ Hispanic-Other
- ☐ Other/Other/Specified
- ☐ Puerto Rican
- ☐ Pacific Islander-not Hawaiian, Guamanian or Samoan
- ☐ Pakistani
- ☐ Palestinian
- ☐ South or Central American
- ☐ Samoan
- ☐ Somalian
- ☐ Spanish
- ☐ Srilankan
- ☐ Thai
- ☐ Vietnamese
- ☐ Unknown/Not Reported
- ☐ Withheld

3. Race (circle one only)

- ☐ Alaskan Native
- ☐ American Indian
- ☐ Asian
- ☐ Black
- ☐ Pacific Islander
- ☐ White
- ☐ Other
- ☐ Unknown

Hispanic Ethnicity?

☐ Yes ☐ No ☐ Unknown

4. Name of Patient's ***Father***: _____
Father's First Name Father's Last Name

EMERGENCY CONTACTS

5. List two (2) names of persons (friends or relatives) who we can contact in case of an emergency:

1.) _____ _____ _____ (_____) _____
(Relationship to Patient) First Name Last Name Area Code Telephone Number

2.) _____ _____ _____ (_____) _____
(Relationship to Patient) First Name Last Name Area Code Telephone Number

Important: *If your child has Medi-Cal, please show the receptionist his/her Medi-Cal BIC ID Card.*

Please fill out the other side