



### Lubbock Children's Health Clinic Enrollment Form

Please have your check stubs, social security and immunization cards ready.  
Demographic Information

**Do you have? Private Insurance Medicaid CHIP**

Patient's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Social Security: \_\_\_\_\_ Medicaid/Insurance: \_\_\_\_\_  
 Patient Insurance Information Plan: \_\_\_\_\_  
 Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Hispanic or Latino \_\_\_\_\_ Non Hispanic or Non Latino Unknown  
 Race: \_\_\_\_\_ American Indian or Alaskan Indian \_\_\_\_\_ Asian \_\_\_\_\_ Black or African American  
 \_\_\_\_\_ Native Hawaiian or other Pacific Islander \_\_\_\_\_ White \_\_\_\_\_ Other  
 Sex: \_\_\_\_\_ Male Female Primary Language: \_\_\_\_\_

Mother's Last Name: \_\_\_\_\_ First: \_\_\_\_\_  
 SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Father's Last Name: \_\_\_\_\_ First: \_\_\_\_\_  
 SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Employer/Employers of Household Members: \_\_\_\_\_

Monthly Income: \_\_\_\_\_ SSI Monthly Payments: \_\_\_\_\_  
 Child Support: \_\_\_\_\_ Unemployment Payments: \_\_\_\_\_ TOTAL INCOME: \_\_\_\_\_  
 List Others in The Household: \_\_\_\_\_ How many live in your household: \_\_\_\_\_

1)	_____	_____	_____	_____
	Last	First	Date of Birth	SS#
2)	_____	_____	_____	_____
	Last	First	Date of Birth	SS#
3)	_____	_____	_____	_____
	Last	First	Date of Birth	SS#

Date: \_\_\_\_\_

How did you hear about the Lubbock Children's Health Clinic: (Please circle one)

- Health Department
- Health Fair
- Newspaper
- Relative/Friend
- TV/Radio
- Website
- Other: (please specify): \_\_\_\_\_