



Patient Label  
For Office Use Only

Sycuan Medical Dental Center  
Tel: (619) 445-0707

Website: <https://www.sycuanmedicaldentalcenter.org>

## MINOR PATIENT REGISTRATION FORM

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
*Print As on ID Last First Middle Initial*

Preferred Name: \_\_\_\_\_ Mother's Maiden Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Preferred Language: \_\_\_\_\_

### Contact Information

Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Email: \_\_\_\_\_

Preferred Contact Method:  Home  Cell  Email Text/Email Appointment Reminder:  Yes  No

Address: \_\_\_\_\_ # \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing: \_\_\_\_\_ # \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
*(If Different from Residence Address)*

### Please provide the Parent/ legal Guardian's information.

Parent/Legal Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Parent/Legal Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

### Tribal Affiliation

*If American Indian/Alaskan Native, please provide your Tribal Affiliation Card:*

Tribal Enrollment #: \_\_\_\_\_ Tribal Affiliation: \_\_\_\_\_

Community/Village of Residence: \_\_\_\_\_ Other Tribal Affiliation: \_\_\_\_\_

Tribal Descendancy:  Mother  Father  Unknown  Tribal Blood Quantum: \_\_\_\_\_

### Insurance Information

Primary Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Policy Holder Address: \_\_\_\_\_

**Preferred Pharmacy**

Primary Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Secondary Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Sexual Orientation and Gender Identity (SOGI)**

Gender Identity:     Male         Female         Other (Please Specify) \_\_\_\_\_  
  
Preferred Pronoun:    He, Him, His         Decline to Specify  
                              She, Her, Hers         Something Else (Please Specify) \_\_\_\_\_  
                              They, Them, Theirs  
  
Ethnicity:             Hispanic/Latino         Non-Hispanic/Non-Latino         Decline to Specify  
  
Race:                 Black/African American     Middle Eastern/North African     Native Hawaiian  
                              Other Pacific Islander     American Indian/Alaskan Native    Asian  
                              White                         Other (Please Specify)                 Decline to Specify

**Work Status**

Are you currently employed?  Yes         No         Student  
*If Employed:*    Full-Time    Part-Time        *If Student:*    Full-Time         Part-Time  
Name of Employer: \_\_\_\_\_ Department: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Address: \_\_\_\_\_  
Gross Income: \$ \_\_\_\_\_ per year     Decline to Specify

**Emergency Contact**

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

As the Patient or Guardian, I certify that the information I am providing to Sycuan Medical Dental Center is true and accurate.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by someone other than the patient, please specify the relation to the Patient: \_\_\_\_\_

***FOR OFFICE USE ONLY:***

Intake by: \_\_\_\_\_ Date Scanned on Patient's Chart: \_\_\_\_\_