**Florida Department of Health in Pinellas County**

Name (child)_____ Date_____

Date of Birth_____ SS #_____ Language Spoken_____

Address_____ City _____ Zip Code_____

Telephone_____ Cell_____ School Attending_____

**Please List All Other Members of the Household**

| Name | Date of Birth | SS# | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**If the client is a Medicaid Recipient, you DO NOT have to complete the rest of this form**

## Financial Information

**(Adults must be uninsured or have Medicaid; Fees are based on declared income)**

**Your:**

Place of Employment_____

Gross Income :$_____(wk )(bw) (mo) (yr)

Child Support $_____

Unemployment Compensation $:_____

AFDC: $ _____ Food Stamps Y /N

Child Care $_____

**Spouse/Parent of child, living in the household**

Place of Employment _____

Gross Income:$_____ (wk) (bw) (mo) (yr)

Child Support $_____

Unemployment Compensation $:_____

AFDC:$ _____ Food Stamps Y /N

Child Care $_____

I understand that if I provide incomplete or inaccurate information, or if I alter forms, I will have my benefits terminated and may be subject to criminal investigation and possible prosecution

**In case of emergency, who should we contact other than the mother or father?**

Name: _____Telephone:_____Relationship:_____

.

Signature _____ Date_____

To the Florida Department of Health in Pinellas County for examination and /or treatment

_____ _____ _____

(Client, Parent and /or Legal Guardian/Representative) (Relationship) (Date)

08/22/13 pc

**(LABEL)**