Access to Baby & Child Dentistry™

Enrollment Form-Children 0-5 Years with Apple Health/Provider One Card

Enrollment Site

Organization:

Staff Name:

Client Referral Source:

Parent Information

Name (First, Last):

E-mail:

Phone: Other Phone:

Address:

City: State: Zip:

County: Language:

Gender: Male ☐ Female ☐ Date of Birth:

Child Information

Name (First, Last):

Date of Birth: **Gender:** Male ☐ Female ☐

Provider One #:

(9-digit number followed by WA)

Race: White ☐ Black ☐ American Indian/Alaskan ☐ Asian ☐ Pacific Islander ☐ Other ☐

Ethnicity: Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Don't Know ☐ Refused ☐

Child Information

Name (First, Last):

Date of Birth: **Gender:** Male ☐ Female ☐

Provider One #:

(9-digit number followed by WA)

Race: White ☐ Black ☐ American Indian/Alaskan ☐ Asian ☐ Pacific Islander ☐ Other ☐

Ethnicity: Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Don't Know ☐ Refused ☐

Fax completed form to Attn: ABCD Coordinator at 360-943-1164

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