

ACKNOWLEDGMENT OF PATERNITY

Check One: At Birth Post Birth

CHILD			
CHILD'S NAME (As it currently appears) (First)		(Middle)	(Last)
SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	SOCIAL SECURITY NO. (If Available)	IS THE CHILD'S NAME TO BE CHANGED? <input type="checkbox"/> NO <input type="checkbox"/> YES *if yes, complete line item below
CHILD'S NAME (As it will appear on new birth certificate) (First)		(Middle)	(Last)
PLACE OF BIRTH		CITY	STATE
MOTHER			
MOTHER'S NAME (First)		(Middle)	(Last)
MAIDEN NAME (If applicable)	DATE OF BIRTH	PLACE OF BIRTH (CITY and STATE OR FOREIGN COUNTRY)	SOCIAL SECURITY NO.
RESIDENCE (No. and Street)		(Town)	(State or Foreign Country) (Zip Code)
RACE <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other (Specify) _____		IS MOTHER OF HISPANIC ORIGIN? <input type="checkbox"/> NO <input type="checkbox"/> YES	If yes, specify: <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Other (Specify) _____
DO YOU HAVE MEDICAL INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO		MEDICAL INSURANCE COMPANY NAME	POLICY NUMBER
FATHER			
FATHER'S NAME (First)		(Middle)	(Last)
DATE OF BIRTH		PLACE OF BIRTH (CITY and STATE OR FOREIGN COUNTRY)	SOCIAL SECURITY NO.
RESIDENCE (No. and Street)		(Town)	(State or Foreign Country) (Zip Code)
RACE <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other (Specify) _____		IS FATHER OF HISPANIC ORIGIN? <input type="checkbox"/> NO <input type="checkbox"/> YES	If yes, specify: <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican <input type="checkbox"/> Other (Specify) _____
EDUCATION LEVEL: (Circle highest level COMPLETED) 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 5+			
EMPLOYER		EMPLOYER'S ADDRESS (include City and State)	
OCCUPATION		BUSINESS/INDUSTRY	
DO YOU HAVE MEDICAL INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO		MEDICAL INSURANCE COMPANY NAME	POLICY NUMBER
MOTHER'S AFFIRMATION		FATHER'S ACKNOWLEDGMENT	
I freely and voluntarily consent to this Acknowledgment of Paternity. The man named above is the biological father of this child. I have read or have had read to me, and have had explained to me, the rights and responsibilities on the back of this form, and I understand the contents. I have had the opportunity to ask questions before I signed this form. A copy of this statement has been given to me. I attest that the above information that I have provided is true and correct to the best of my knowledge.		I freely and voluntarily acknowledge that I am the biological father of the child named above, I accept the obligation to support this child. I understand that an order for child support may be entered. I waive my rights to a trial, a lawyer to represent me and a genetic test to determine paternity. I have read or have had read to me, and have had explained to me, the rights and responsibilities on the back of this form, and I understand the contents. I have had the opportunity to ask questions before I signed this form. A copy of this statement has been given to me. I attest that the above information that I have provided is true and correct to the best of my knowledge.	
Mother's Signature (use current last name) _____ Date _____		Father's Signature _____ Date _____	
State of _____, County of _____ Town of _____ Sworn and subscribed before me on this _____ Day of _____, _____		State of _____, County of _____ Town of _____ Sworn and subscribed before me on this _____ Day of _____, _____	
Commissioner of the Superior Court/Investigator/Other Officer _____ Notary Public My Commission expires on _____		Commissioner of the Superior Court/Investigator/Other Officer _____ Notary Public My Commission expires on _____	
PLACE COMPLETED	Place where acknowledgment was completed, for example, hospital name, Dept. of Social Services (DSS), Regional Office (specify location), or Dept. of Public Health (DPH)	PLACE COMPLETED	Place where acknowledgment was completed, for example, hospital name, Dept. of Social Services (DSS), Regional Office (specify location), or Dept. of Public Health (DPH)