

LOCAL HEALTH DEPARTMENT PATERNITY AFFIDAVIT QUESTIONNAIRE
JOHNSON COUNTY HEALTH DEPARTMENT

CHILD'S NAME: _____ Date of Birth _____ - _____ - _____

Place of Birth: Hospital _____ City _____

County _____ State _____ Less than 60 Days old _____ More than 60 old _____

FATHER'S FULL LEAGAL NAME: _____

Social Security Number _____ - _____ - _____ Date of Birth _____ - _____ - _____

Place of Birth: City _____ State _____ County _____

Current Address _____

City _____ State _____ Zip Code _____

Phone number _____

MOTHER'S FULL LEAGAL NAME: _____ Maiden name: _____

Social Security Number _____ - _____ - _____ Date of Birth _____ - _____ - _____

Place of Birth: City _____ State _____ County _____

Current Address _____

City _____ State _____ Zip Code _____

Phone number _____

PATERNITY UPON MARRIAGE:

The surname of the child has been registered in the certificate of birth under the surname of the mother and we are acknowledging that we were legally married on _____ - _____ - _____.

By the authority of a marriage license issued by _____, and
(County & State)
that this marriage has been continuous since that date.

SIGNATURES _____ FATHER _____ MOTHER

It is our desire that the name of our child on the Indiana Certificate of Birth shall be recorded as:

FIRST NAME

MIDDLE NAME (S)

LAST NAME

Gender: M F Last 4 digits of Child's Social Security Number _____

MOTHER'S INITIALS _____ Father's Initials _____