Patient Information Form

Appointment Date:

Please notify the front desk if any of the following information is incorrect so that we can keep our records up to date.

Patient Information

Legal Name: Last .... **First** .... **M.I.** ....

Birth Date: .... **Sex:** .... **email:** ....

Billing Address: .... **City:** .... **State:** .... **ZIP:** ....

Secondary Address: .... **City:** .... **State:** .... **ZIP:** ....

Primary Phone: .... **Secondary Phone:** ....

Race: .... **Ethnicity:** .... **Preferred Language:** ....

Primary Care Provider: .... **Are you presently homeless?** ....

Primary Dental Provider: .... **Do you reside in public housing?** ....

Do you or a member of your family engage in agricultural work? ....

Over the past 24 months have you or a member of your family?

Been hired to do agricultural work?	Y	or	N
Earned the majority of your income or employment from agricultural work?	Y	or	N
Moved temporarily in order to do agricultural work?	Y	or	N
Have you stopped working in agriculture due to age or disability?	Y	or	N

Have you (patient) completed service in the Uniformed Services of the United States? ....

Person to Notify in Case of Emergency (Spouse, Parent, Guardian or Other)

Guarantor Information (Person responsible for payment of account/services)

Sliding Fee Discount Program Information

The following information is collected for Federal reporting purposes and to qualify for a sliding fee discount. Failure to disclose this information will disqualify you from receiving a sliding fee discount.

What is your Approximate gross annual household income? ....

How many family members are supported by this income? ....

Current Insurance

Consent to Treat and Authorization to Pay Benefits to Valley-Wide Health Systems, Inc.

I hereby authorize payment directly to Valley-Wide Health Systems, Inc. for medical/dental benefits. I understand that I am financially responsible to Valley-Wide Health Systems, Inc. for services not paid by insurance or other third party payors. I understand that if I have been issued a refund check and it is returned as undeliverable after reasonable attempts to contact have been unsuccessful, such check will be considered a donation to the clinic. I also agree that if I fail to cash a refund check within 1 year of issuance, the refund check will be considered as a donation to VWHS.

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SIGNATURE OF PATIENT (if patient is over age 18, GUARDIAN (if patient is under age 18), or WITNESS (if adult patient is unable to sign)

I consent to treatment and care by Valley-Wide Health Systems, Inc. I understand that my treatment and care may include routine care, such as immunizations, and a variety of other medical services depending on my condition. I understand that my care team may include residents, students or other trainees.

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SIGNATURE OF PATIENT (if patient is over age 18, GUARDIAN (if patient is under age 18), or WITNESS (if adult patient is unable to sign)

Have you received any care or services elsewhere since your last visit? No ☐ Yes ☐

What is your healthcare goal? ______________________________

Please put a mark in the **Y** column if you are currently taking this medication, a mark in the **N** column if you have stopped taking this medication, a mark in the **Q** column if you have questions about this medication and/or a mark in the **R** column if you need a refill. Please also include any over the counter and/or herbal medications you are taking.

Y	N	Q	R	
☐	☐	☐		**Our records do not show any medications listed for you, please inform our clinical staff if you are taking any medications.**

Patient Name: DOB: