Valley Professionals Community Health Center
CARING PROFESSIONALS IN YOUR COMMUNITY.

Registration - Adult

Patient Information

Name _____ Birthdate: _____

Address: _____ City/State/Zip: _____

Home phone: _____ Cell: _____ Work: _____

Email: _____

Responsible Party ☐ Same as above ☐ Different from patient (please complete below)

Relationship to patient: _____

Name: _____ Birthdate: _____

Address: _____ City/State/Zip: _____

Home phone: _____ Cell: _____ Work: _____

Emergency Contact Information

Name: _____ Relationship to patient: _____

Home phone: _____ Cell: _____

Valley Professionals is a Federally Qualified Health Center that receives government funding. The funding for the health center is based on the information you provide and is necessary for us to serve our patients. Please complete the following information for reporting purposes.

Race ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American ☐ White ☐ American Indian/Alaska Native ☐ More than one race ☐ Choose not to disclose

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Choose not to disclose

Language ☐ English ☐ Spanish ☐ Other: _____ **Interpreter** ☐ Yes ☐ No

Birth Gender ☐ Male ☐ Female

Gender Identity ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Other ☐ Choose not to Disclose

Sexual Orientation ☐ Straight ☐ Gay or Lesbian ☐ Bisexual ☐ Something else ☐ Don't know ☐ Choose not to Disclose

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Household Size _____ **Annual Income** _____ **Homeless** ☐ Yes ☐ No

Migrant Worker ☐ Yes ☐ No **Seasonal Worker** ☐ Yes ☐ No

Military Service ☐ Yes ☐ No

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Do you have an advance directive? ☐ Yes ☐ No

If yes, (please select all that apply) ☐ Do not Intubate ☐ Do not Resuscitate

☐ Health Care Representative Appointment ☐ Living Will Declaration

☐ Life Prolonging Procedures Declaration ☐ Physician Ordered Scope of Treatment

Pharmacy: _____

Name Location/Address

Our electronic medical record system allows us to collect and review your medication history. This list is collected from various sources, including your pharmacy, healthcare plan and other healthcare providers. Knowing your medication history allows our providers to treat you properly and avoid potential drug interactions. This information will become part of your medical record. You have the right to revoke this authorization, in writing, at any time by sending written notice to Valley Professionals.

Communication Preferences: *(for appointment reminders, Rx confirmations, etc.)*

Language: ☐ English ☐ Spanish

Type: *(choose one)* ☐ Voice ☐ Text

Contact number: *(choose one)* ☐ Home ☐ Cell ☐ Work Number_____

Release of Information:

I hereby authorize Valley Professionals Community Health Center to release/discuss my protected health information with the following individuals:

Name: _____ Relationship: _____ Contact number: _____

Name: _____ Relationship: _____ Contact number: _____

I understand I have the right to revoke this authorization, in writing, at any time by sending written notice to Valley Professionals. If I revoke the authorization, this will not apply to any information that has already been released based on the authorization or to information that Valley Professionals has used based on the authorization. For questions on the use and disclosure of information, I can contact Valley Professionals.

Health Insurance Information: Do you have? ☐ Yes ☐ No – ask us about our Sliding Fee Discount

Primary Insurance:_____Policy Number:_____

Group Number:_____Policy Holder (Name on card): _____

Policy Holder Date of Birth:_____Relationship to patient: _____

Secondary Insurance:_____Policy Number:_____

Group Number:_____Policy Holder (Name on card): _____

Date of Birth:_____Relationship to patient: _____

By signing below, I confirm that the information above is correct to the best of my knowledge:

_____

Patient Signature Date