

PATIENT INFORMATION FORM

Valley-Wide Health Systems, Inc.

DATE: _____

ACCOUNT#: _____

PATIENT INFORMATION

Legal Name: Last _____ First _____ M.I. _____
Birth Date: ____ / ____ / ____ Social Security #: ____ - ____ - ____ Sex: M F
Physical Address: _____ City: _____ State: _____ Zip: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Permanent Address: _____ City: _____ State: _____ Zip: _____
Phone(S): Home: (____) _____ - _____ Message Or Cell: (____) _____ - _____
Previous Doctor/Dentist: Name: _____ City: _____ State: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY (SPOUSE, PARENT, GUARDIAN, OR OTHER)

Name: _____ Relationship to Patient: _____ Phone: (____) _____ - _____

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT/SERVICES)

Legal Name: Last _____ First _____ M.I. _____
Birth Date: ____ / ____ / ____ Social Security # ____ - ____ - ____ Relationship to Patient _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Phone(s) Home: (____) _____ - _____ Message or Cell: (____) _____ - _____
Employer: _____ Work Phone: (____) _____ - _____

OTHER INFORMATION

What is patient's primary language? English Spanish Konjobal Other: _____
Over the past 24 months, have you (patient) or a member of your family:
Been hired to do agricultural work? Yes No
Earned the majority of your income or employment from agricultural work? Yes No
Moved temporarily in order to do agricultural work? Yes No
Are you presently homeless? Yes No
US Veteran status: Have you (patient) completed service in the Uniformed Services of the United States? Yes No
Ethnicity (Voluntary information): Check one of the following ethnic groups that best pertains to you (patient).
 Hispanic / Latino Non-Hispanic / Non-Latino
Race (Voluntary information): Check one of the following racial groups that best pertains to you (patient).
 Asian Native Hawaiian Other Pacific Islander
 Black/African American (including Blacks or African Americans of Latino/Hispanic descent)
 American Indian/Alaska Native (including American Indians or Alaska Natives of Latino/Hispanic decent)
 White (including Whites of Latino/Hispanic descent)
 More than one race
The following information is collected for federal reporting purposes only and will remain confidential:
What is your approximate gross annual household income? \$ _____
How many family members are supported by this income? _____
 I choose not to disclose this information with the understanding there will be no further financial screening completed at this time.
★ You may qualify for a reduced fee for health care services. Please ask our staff for more information. Referred to Casemanagement

Authorization for release of patient information for an audit: I hereby authorize release of patient information for audit use during random chart selection for audits utilized to ensure quality care performance. I understand that my personal information will be reported either in aggregate or so as not to be identified by unauthorized individuals. Yes No

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 I am financially responsible to Valley-Wide Health Systems, Inc. for services not paid by insurance or other third party payors. I hereby certify the information provided is correct and true to the best of my knowledge.

X _____ Date: ____ / ____ / ____
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)

INFORMATION VERIFICATION

Patient/guardian shall review information above as well as the insurance information on the back of this page at each visit. If information has changed, please notify staff to correct information.

If there are no changes in information, please initial and date below.

Date	Patient Initials	VWHS Staff Initials	Date	Patient Initials	VWHS Staff Initials
/ /	_____	_____	/ /	_____	_____
/ /	_____	_____	/ /	_____	_____
/ /	_____	_____	/ /	_____	_____
/ /	_____	_____	/ /	_____	_____

Valley-Wide Health Systems, Inc. does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: Human Resources Director, VWHS, Business Office, (719) 589-5161.

Thank you for completing/updating the Patient Information Form

This section is to be completed by Valley-Wide Health Systems, Inc. staff only.....

- Migrant
- Seasonal Farmworker
- Homeless

Voter Registration: _____
 Patient Handbook: _____

INSURANCE INFORMATION	
PATIENT NAME:	_____
MEDICARE #:	_____
MEDICAID #:	_____
PCP NAME:	_____
INSURANCE:	_____
GROUP NUMBER:	_____
SUBSCRIBER NAME:	_____
SUBSCRIBER #:	_____
EFFECTIVE DATE:	_____
Patient's relationship to Subscriber:	
<input type="checkbox"/> Self	<input type="checkbox"/> Spouse <input type="checkbox"/> Child
<input type="checkbox"/> Other:	_____
PAYOR SOURCE	
C/MCH: Code: _____ Exp. Date: _____	Card #: _____
CICP: Code: _____ Exp. Date: _____	SS#: _____ - _____ - _____