

Patient Information Form

At Valley-Wide, we want to make sure we are serving our diverse population effectively and that we are providing the best treatment to everyone. To help us make sure this remains a focus for us, our Federally Qualified Health Center (FQHC) status requires us to ask and report all demographic data, including primary language, housing needs, Agricultural experiences, Sexual Orientation and Gender Identity for our patients. We share information about our health center as a whole, but we do not share information about individual patients. We are asking all our patients these questions in order to make sure your care is holistic and appropriate for you. If you have questions about this, please ask to speak to the Clinic Manager.

Today's Date_ Aiddle Initial

Patient First Name		Patient Last Name			Middle Initial	Date of Birth		Phone #
Parent or Guardian Name (If applicable)		Billing Address			City	State		Zip
Email Address Mai		Mailing Add	Mailing Address (if different)		City	State		Zip
Guarantor Name (Responsible for payment)		Guarantor Address:			City	State	Zip	Date of Birth
Emergency Contact & Relationship					Emergency Contact Phone #			
Primary Medical Provider				Primary Dental Provider				
Primary Medical Insurance	Policy #		Group	#	Secondary Med	Policy #		Group #
Primary Dental Insurance	Policy #		Group	#	Secondary Dent	Policy #		Group #
What is the language you speak at home? Do you need assis			d assista Y	ance with interpretation? Are you experiencing homelessness? Y N				
Do you Reside in Public Housing?	Y N	Have	you disc	harged from	the United States I	Military or A	Armed Fo	rces? Y N
Race - please circle all that apply				Ethnicity - please circle all that apply				
White American Indian		Pacific Islander		Hi	Hispanic or Latino Other		ther	
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Signature	Printed Name
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