Today's Date: _____

Valley-Wide Health Systems, Inc.
Your Health, Our Priority!

Patient Information Form

At Valley-Wide, we want to make sure we are serving our diverse population effectively and that we provide the best treatment for 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 demographic data. We share information about our health center overall, but we do not share information about individual patients. If you have questions about this, please ask to speak to the Clinic Manager.

Patient First Name	Patient Last Name	Middle Init	Date of Birth	Sex Assigned at Birth Male Female
Parent or Guardian Name (If applicable)	Billing Address	City, State, Zip		
Email Address	Mailing Address (if different)	City, State, Zip		Phone Number
Guarantor Name (Responsible for payment)	Guarantor Address:	Guarantor's City, State, Zip		Guar. Date of Birth

Emergency Contact & Relationship	Emergency Contact Phone #
Primary Medical Provider	Primary Dental Provider

Primary Medical Ins.	Policy #	Group #	Primary Dental Ins.	Policy #	Group #
Secondary Medical Ins.	Policy #	Group #	Secondary Dental Ins.	Policy #	Group #

What is the language you speak at home?	Do you need assistance with interpretation? Y N	Are you experiencing homelessness? Y N
Do you reside in Public Housing? Y N	Have you discharged from the United States Military or Armed Forces? Y N	

Race - **please circle all that apply**	**Ethnicity** - **please circle all that apply**
White American Indian Pacific Islander Black/African American Native Hawaiian Asian I choose not to disclose this information	Hispanic or Latino Other Not Hispanic or Latino Unknown I choose not to disclose this information

Are you or a family member an agricultural (Ag) worker? Y N	**In the last 24 months have you or a family member:**	Moved temporarily to do Ag Work? Y N	Stopped working in Ag due to age or disability? Y N

What is your Family/Household Size? _____	What is your Annual Household Income?	$_____ Please provide the amount above or circle the option below I choose not to disclose this information

Patient/Guardian Signature_____