Delaware Valley Community Health, Inc.
1412 Fairmount Avenue
Philadelphia, PA 19130-2908

☐ **FAIRMOUNT PRIMARY CARE CENTER**
☐ **MARIA DE LOS SANTOS HEALTH CENTER**
☐ **NORRISTOWN REGIONAL HEALTH CENTER**
☐ **PARKVIEW HEALTH CENTER**
☐ **FAIRMOUNT PRIMARY CARE AT HORIZON HOUSE**
☐ **FAIRMOUNT PRIMARY CARE AT ST. JOSEPH'S HOSPITAL**

PATIENT INFORMATION

NAME (Last, First, Middle)	SSN#	D.O.B.	SEX

STREET ADDRESS	CITY, STATE, ZIP

RACE
☐ Black/African American ☐ White ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ American Indian (May check off more than one race)

The following questions are asked because we are a federally qualified health center. This information is confidential and for reporting purposes only.

PREFERRED LANGUAGE	ETHNICITY ☐ Hispanic ☐ Non-Hispanic	MARITAL STATUS	PHONE NUMBER (H) (C)

VETERAN ☐ Yes ☐ No	EMAIL ADRESS:	FAMILY SIZE (Including yourself)

WHO IS FINANCIALLY RESPONSIBLE FOR YOUR HOUSEHOLD?	D.O.B.	INCOME (Monthly) (Yearly)

EMERGENCY CONTACT (Relationship)	PHONE NUMBER (H) (C)

GUARANTOR (Who is paying for today's visit?) ■ Check if same as above

NAME (Last, First, Middle)	SSN#	D.O.B.

STREET ADDRESS	CITY, STATE, ZIP	PHONE NUMBER (H) (C)

RELEASE OF INSURANCE INFORMATION AND ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare, Medicaid, Medicaid HMO or commercial insurance benefits be made, on my behalf, to Delaware Valley Community Health, Inc. for any services furnished me by their medical, dental, mental health or social work staff. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid services or commercial insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

INSURANCE	ID NUMBER

INSURANCE	ID NUMBER

PATIENT/PARENT/GUARDIAN SIGNATURE	DATE

AUTHORIZATION OF TREATMENT

I hereby authorize Delaware Valley Community health, Inc. to administer such medications, local anesthetics and immunizations; and to perform such diagnostic procedures as may be necessary for any proper heath care. This includes oral surgery, general medicines, and other consultation and counseling. By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations. You have the right to read our Notice of Privacy before you decide whether to sign this consent.

PATIENT/PARENT/GUARDIAN SIGNATURE	DATE

ADDITIONAL AUTHORIZATION (Optional)

I authorize _____ and/or _____
NAME OF PERSON (Relationship) NAME OF PERSON (Relationship)

to be part of my medical care and to access my medical records and obtain referrals on my behalf.

PATIENT/PARENT/GUARDIAN SIGNATURE	DATE