Grand Valley Health Family Health Centers

Today's Date:

GRAND VALLEY FAMILY HEALTH CENTER PERSONAL INFORMATION UPDATE

Patient Name:	Date of Birth:	Person Completing Form:

Name I prefer to be called:	I prefer to be contacted by: ☐ Day Phone ☐ Home/Alternative Phone ☐ E-mail ☐ Other: _____

Address:	City:	State:	Zip:

Occupation:	Day Phone:	Home/Alternative Phone:

My Preferred Medical Provider at my GVHP Family Health Center is:

E-mail: ☐ I do not have e-mail ☐ I prefer not to provide

Legal Guardian: ☐ Self ☐ Parent ☐ Other	Name of Legal Guardian (if not self)	Phone Number:

My Preferred SPOKEN Language is:

☐ English ☐ Spanish ☐ Bosnian ☐ American Sign
☐ Vietnamese ☐ Korean ☐ I prefer not to answer ☐ Other: _____

My Preferred WRITTEN Language is:

☐ English ☐ Spanish ☐ Bosnian ☐ Vietnamese
☐ Korean ☐ I prefer not to answer ☐ Other _____

Race-Check all that apply:

☐ Asian ☐ Black or African American ☐ White ☐ American Indian/Alaska Native
☐ Hawaiian/Pacific Islander ☐ Unknown ☐ I prefer not to answer ☐ Other: _____

Ethnicity-Check all that apply:

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Not applicable ☐ Prefer not to answer

Sensory Impairments (select all that apply)

☐ I am visually impaired ☐ I am hearing impaired ☐ Not applicable

Family Details (if applicable)

Name of spouse or significant other:

Name and age of children:

Primary Caregiver ☐ Self ☐ Parent ☐ Other	Name of Caregiver (if not self)	Phone:

Emergency Contact Information:

Name:	Relationship:

Address:	City:	State:	Zip:

Phone:	Alternative Phone:

Advanced Directives and Healthcare Proxy

☐ I have an Advanced Directive ☐ I would like to talk about Advanced Directives
☐ I am not interested in Advanced Directives at this time and/or am under 18 years of age
☐ I have a Healthcare Proxy ☐ I do not have a Healthcare Proxy

My Healthcare Proxy's Name:	Phone: