Grand Valley Health Family Health Centers

Today's Date:

GRAND VALLEY FAMILY HEALTH CENTER PERSONAL INFORMATION UPDATE

Welcome to Grand Valley Family Health Center! Thank you for choosing us as your healthcare provider. If you have any questions, please do not hesitate to call us at (616) 224-1515. We're here to help!

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	Previous GVHP Member ☐ Yes ☐ No

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:

How did you hear about us? Please select all that apply and be specific if possible:

☐ Family/Friend ☐ Employer ☐ Insurance Provider ☐ Mailing

☐ Community Event Which one? _____ ☐ Online ☐ HealthWORKS ☐ Other:

In order to address your specific need, please describe what you would like to focus on, to help improve your health, wellness or quality of life:

_____

_____

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:

Please continue onto the back side of page

Grand Valley Health
Family Health Centers

Today's Date:

Annual Income Level			
☐ Unemployed	☐ $0-$30,000	☐ $31,000-$40,000	☐ $41,000-$50,000
☐ $51,000-60,000	☐ $61,000-$80,000	☐ $81,000-$100,000	☐ >$100,000

Highest Level of Education		
☐ Did Not Finish High School	☐ GED	☐ High School Diploma
☐ Some College	☐ College Degree	☐ Grad/DOC Degree

Which Religion or faith do you identify with? Please specify (i.e. Catholic, Protestant, Jewish, N/A etc.)

_____

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:

Primary Insurance Information - (First Payer)

Primary Insurance: Check appropriate box: ☐ Priority ☐ BCBC/BCN ☐ Tricare ☐ Medicaid MHP/Medicare ☐ Other _____

Name of Subscriber	Policy #	Birthdate:
_____	_____	_____

Other Insurance Information - (Second/Third Payer)

Secondary Insurance: Check appropriate box: ☐ Priority ☐ BCBC/BCN ☐ Tricare ☐ Medicaid MHP/Medicare ☐ Other _____

Name of Subscriber	Policy #	Birthdate:
_____	_____	_____

Third Insurance: Check appropriate box: ☐ Priority ☐ BCBC/BCN ☐ Tricare ☐ Medicaid MHP/Medicare ☐ Other _____

Name of Subscriber	Policy #	Birthdate:
_____	_____	_____

Please present any active insurance identification cards with this form. In addition, you may be asked, at the time of service, to present proof of identity or insurance.

In signing this form, I agree to the following:

1. I acknowledge GVFHC's right to conduct utilization review programs of health services and to coordinate benefits and or reimbursements with the above-mentioned insurance carriers.
2. I have received and agree to the Office Financial Policy of GVFHC
3. I have been offered the HIPPA Notice of Privacy Practices

Signature: _____ Date: _____