

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: <input type="checkbox"/> Day Phone <input type="checkbox"/> Home/Alternative Phone <input type="checkbox"/> E-mail		Previous GVHP Member <input type="checkbox"/> Yes <input type="checkbox"/> No
Address:		City:	State: Zip:
Occupation:	Day Phone:	Home/Alternative Phone:	
My Preferred Medical Provider at my GVHP Family Health Center is:			
E-mail: <input type="checkbox"/> I do not have e-mail <input type="checkbox"/> I prefer not to provide			
Legal Guardian: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> 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:			
<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Employer	<input type="checkbox"/> Insurance Provider	<input type="checkbox"/> Mailing
<input type="checkbox"/> Community Event Which one? _____	<input type="checkbox"/> Online	<input type="checkbox"/> HealthWORKS	<input type="checkbox"/> 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:			
<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Bosnian	<input type="checkbox"/> American Sign
<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Korean	<input type="checkbox"/> I prefer not to answer	<input type="checkbox"/> Other: _____
My Preferred WRITTEN Language is:			
<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Bosnian	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Korean	<input type="checkbox"/> I prefer not to answer	<input type="checkbox"/> Other	_____
Race -Check all that apply:			
<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White	<input type="checkbox"/> American Indian/Alaska Native
<input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> Unknown	<input type="checkbox"/> I prefer not to answer	<input type="checkbox"/> Other: _____
Ethnicity -Check all that apply:			
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Non-Hispanic/Latino	<input type="checkbox"/> Unknown	<input type="checkbox"/> Not applicable
<input type="checkbox"/> Prefer not to answer			
Sensory Impairments (select all that apply)			
<input type="checkbox"/> I am visually impaired	<input type="checkbox"/> I am hearing impaired	<input type="checkbox"/> Not applicable	
Family Details (if applicable):			
Name of spouse or significant other:			
Name and age of children:			
Primary Caregiver <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> 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			

Annual Income Level				
<input type="checkbox"/> Unemployed	<input type="checkbox"/> \$0-\$30,000	<input type="checkbox"/> \$31,000-\$40,000	<input type="checkbox"/> \$41,000-\$50,000	
<input type="checkbox"/> \$51,000-60,000	<input type="checkbox"/> \$61,000-\$80,000	<input type="checkbox"/> \$81,000-\$100,000	<input type="checkbox"/> >\$100,000	
Highest Level of Education				
<input type="checkbox"/> Did Not Finish High School	<input type="checkbox"/> GED	<input type="checkbox"/> High School Diploma		
<input type="checkbox"/> Some College	<input type="checkbox"/> College Degree	<input type="checkbox"/> 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				
<input type="checkbox"/> I have an Advanced Directive		<input type="checkbox"/> I would like to talk about Advanced Directives		
<input type="checkbox"/> I am not interested in Advanced Directives at this time and/or am under 18 years of age				
<input type="checkbox"/> I have a Healthcare Proxy		<input type="checkbox"/> I do not have a Healthcare Proxy		
My Healthcare Proxy's Name: _____			Phone: _____	
Primary Insurance Information - (First Payer)				
Primary Insurance: Check appropriate box: <input type="checkbox"/> Priority <input type="checkbox"/> BCBC/BCN <input type="checkbox"/> Tricare <input type="checkbox"/> Medicaid MHP/Medicare <input type="checkbox"/> Other _____				
Name of Subscriber _____		Policy # _____		Birthdate: _____
Other Insurance Information - (Second/Third Payer)				
Secondary Insurance: Check appropriate box: <input type="checkbox"/> Priority <input type="checkbox"/> BCBC/BCN <input type="checkbox"/> Tricare <input type="checkbox"/> Medicaid MHP/Medicare <input type="checkbox"/> Other _____				
Name of Subscriber _____		Policy # _____		Birthdate: _____
Third Insurance: Check appropriate box: <input type="checkbox"/> Priority <input type="checkbox"/> BCBC/BCN <input type="checkbox"/> Tricare <input type="checkbox"/> Medicaid MHP/Medicare <input type="checkbox"/> 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: _____