Hyndman Area Health Center Inc.
144 Fifth Avenue P.O. Box 706
Hyndman, Pennsylvania 15545
Phone: (814) 842-3206 Fax: (814) 842-9169
hyndmanhealth.org

PATIENT'S NAME (PLEASE INCLUDE NAME SUFFIX IF APPLICABLE)			
LAST	FIRST	MIDDLE	MAIDEN OR SUFFIX

ADDRESS			
PO BOX/STREET	ZIP CODE	CITY	STATE

HOME PHONE NUMBER	CELL PHONE NUMBER	SOCIAL SECURITY NUMBER	SEX (CIRCLE ONE) MALE FEMALE

MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED WIDOWED DIVORCED SEPARATED	BIRTHDATE	RACE (CIRCLE ONE) WHITE BLACK/AFRICAN AMERICAN AMERICAN INDIAN/ALASKA NATIVE HISPANIC ASIAN/PACIFIC ISLANDER UNREPORTED/REFUSED

ALLERGIES (PLEASE CIRCLE ONE): YES NO
IF YES, PLEASE LIST:

EMERGENCY CONTACT INFORMATION			
CONTACT NAME	RELATIONSHIP	HOME PHONE NUMBER	CELL PHONE NUMBER
SECOND CONTACT NAME	RELATIONSHIP	HOME PHONE NUMBER	CELL PHONE NUMBER

PATIENT'S EMPLOYMENT INFORMATION			
OCCUPATION		EMPLOYER'S NAME	
EMPLOYER'S ADDRESS			
STREET	ZIP CODE	CITY	STATE
EMPLOYER'S PHONE NUMBER			

GUARANTOR/PRIMARY CARDHOLDER'S INFORMATION			
LAST NAME	FIRST NAME	MIDDLE	BIRTHDATE
SOCIAL SECURITY NUMBER	OCCUPATION		SEX (CIRCLE ONE) MALE FEMALE
GUARANTOR'S EMPLOYER NAME		EMPLOYERS' PHONE NUMBER	
GUARANTOR'S EMPLOYER ADDRESS			
PO BOX/STREET	ZIP CODE	CITY	STATE

INSURANCE INFORMATION			
PRIMARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER	INSURANCE PHONE NUMBER
INSURANCE STREET ADDRESS	ZIP CODE	CITY	STATE
SECONDARY INSURANCE NAME	POLICY NUMBER	GROUP NUMBER	INSURANCE PHONE NUMBER

I give permission for treatment and request that payment of authorized benefits is made on my behalf to the Hyndman Area Health Center, Inc. for any services rendered to me by their medical and/or dental providers. I authorize Hyndman Area Health Center, Inc. to release medical and/or dental information to my current insurance company and its agents to determine these benefits or the benefits payable for related services.

PATIENT'S SIGNATURE PRINT NAME DATE OF SIGNATURE

SIGNATURE OF PARENT/GUARDIAN PRINT NAME DATE OF SIGNATURE
IF PATIENT IS A MINOR

Affordable Health Care for the Entire Family