**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*