Department of Health Bradford County
Department of Health Union County
New River Health Center

PATIENT INFORMATION

Last Name	**First Name**	**Middle Initial**

Date of Birth	**Social Security Number**	**Sex at Birth (☑ one)** ☐ Male ☐ Female

Address	**City**	**State**	**Zip Code**	**County**

AKA (another name you go by or prefer to be called):	**Telephone Number and type:**

E-mail Address:

Gender (☑ one):
☐Male ☐Female ☐Transgender Male/Female-to-Male ☐Transgender Female/Male-to-Female ☐Other ☐Choose Not To Answer

Sexual Orientation (☑ one):
☐Choose Not to Answer ☐Lesbian or Gay ☐Straight (not lesbian or gay) ☐Bisexual ☐Something Other ☐Don't know

Race (☑ one): ☐Asian ☐ Native Hawaiian ☐Other Pacific Islander ☐Black/African American
☐American Indian/Alaska Native ☐White

Primary Language Spoken: **Do you need an interpreter?** ☐ Yes ☐ No

Marital Status (☑ one):
☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced ☐ Unknown

U.S. Military Veteran (☑ one):
☐ Yes ☐ No

Ethnicity (☑ one): ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Country of Birth: _____

Date you arrived in the United States: _____ **Year**_____

Are you a migrant worker or a family member of a migrant worker? ☐ Yes ☐ No

Highest Level of education:

Living Quarters (☑ one): ☐ Rent ☐ Own ☐ Live with family/friends
☐ Homeless ☐ Other Housing Arrangements ☐ Unstable

How many rooms in total do you have where you currently live?

What method(s) do you use to heat and cool your home with?

Check the working items you have: ☐ Refrigerator ☐ Cooking stove ☐ Hot plate ☐ Fan ☐ Indoor toilet
☐ Water inside for drinking ☐ Water inside for bathing

Advance Directives: I understand that I have the right to have an advance directive.
☐ I currently have an advance directive:
☐ Living Will ☐ Health Care Surrogate ☐ Durable Power of Attorney for Health Care

☐ I do not have or want an advance directive ☐ I would like more information regarding advance directives

If you already have an advance directive, please bring a copy with you at your next visit. Your advance directive will be placed in your medical record.

The Department of Health Bradford, Department of Health Union, New River Health Center does not deny anyone services because of race, national origin, skin color, religion, sexual orientation, physical handicap, disability, source of payment, or the inability to pay and uses recent Federal Poverty Guidelines to establish a sliding fee scale for eligible low-income patients.

_____ _____ _____
SIGNATURE OF CLIENT/PARENT or GUARDIAN **SIGNATURE OF DEPARTMENT OF HEALTH EMPLOYEE** **DATE**

PATIENT ACCOUNT INFORMATION

Person responsible for payment:

Last Name	First Name	Middle Initial

Social Security Number	Date of Birth	Telephone Number and type:

Address (if different from patient)	City	State	Zip Code	County

INSURANCE INFORMATION

Do you have insurance that covers your health condition? ☐ Yes ☐ No

Name of Insurance Company	Policy Number	Group Number

Name of the card holder (Insured)

I understand that I will be assigned to the full fee category and that I am responsible for any charges denied or not paid by my insurance. I also authorize the payment of medical benefits to the Department of Health Bradford, Department of Health Union, New River Health Center. Payment is due at the time services are rendered, unless prior arrangements have been made. Past due accounts may be referred to a collection agency.

_____ _____ _____

SIGNATURE OF CLIENT/PARENT or GUARDIAN **SIGNATURE OF DEPARTMENT OF HEALTH EMPLOYEE** **DATE**

EMPLOYMENT

Employment Status	Employer:	What is your occupation?
☐ Employed ☐ Not Employed	Start Date:	

SLIDING FEE DETERMINATION

Enter income for your complete household or family unit - List each family member in household and include ALL types of income. *Documentation* will have to be provided in order to complete sliding fee determination.

NAME	Date of Birth	FAMILY RELATIONSHIP	Place of Employment or Other Source of Income	Income before Taxes or Deductions.
1.		Patient		$ WK BW MO
2.				$ WK BW MO
3.				$ WK BW MO
4.				$ WK BW MO
5.				$ WK BW MO
6.				$ WK BW MO
7.				$ WK BW MO
8.				$ WK BW MO

Do you pay child support? ☐ No ☐ Yes – **How much a month?** $_____

Do you pay for child care? ☐ No ☐ Yes – **How much a month?** $_____

I was provided a copy of the Primary Care/Family Planning Services Information sheet on _____ _____

Interview Clerk initials _____ (Date) (Pt. initials)