SONOMA VALLEY
COMMUNITY HEALTH CENTER

Last Name	First Name	Middle Name	
Social Security Number	Date of birth (mm/dd/yyyy)	Gender at birth: □ Male □ Female	Who is your Medical Provider?
Street address		Are you transgender? □ Yes □ No If Yes: □ Trans- Male to Female or □ Trans–Female to Male	
City State Zip		What is your marital status?(check one) □ Divorced □ Married □ Single □ Domestic partner □ Separated □ Widowed	
Is it OK to send mail to your address? □ Yes □ No			
Home phone number	Cell phone number	Preferred Language with Clinician?	Do you need an Interpreter? □ Yes □ No
Please select one of the following from the ethnicity listing: □ Hispanic □ Not Hispanic		Email Address:	

Please check one of the following from the race listing:
□ Asian □ Native Hawaiian □ Other Pacific Islander □ Black/African American □ American Indian/Alaskan Native
□ White □ More than One Race

EMERGENCY CONTACT INFORMATION

Emergency contact: Spouse, Friend, Legal Guardian or Parent (if patient is a minor)	Relationship to patient	Phone number

Student Status:(check one)
□ Student full time □ Student part time □ Minor

Are you a veteran of US Armed Forces? □ Yes □ No

Do you have a physical or mental disability that has prevented or will prevent you from working for more than a year?
□ Yes □ No

GUARANTOR INFORMATION

Last Name First Name Middle Name		
Street address	Date of birth (mm/dd/yyyy)	Gender: □ Male □ Female
City State Zip	Phone Number	Relationship to patient

INSURANCE

Insurance company	Start date	
Employer	ID #	Group #
Policy holder	Policy holder's date of birth	Policy holder's social security #

HEALTH CENTER FUNDING INFORMATION

How many people in your family? (yourself, spouse and minor children under 18 years)	What is your household annual income? (income of the persons listed in your family if they are working)

How did you hear about our clinic? (Please check all that apply)
□ SVCHC Employee □ SVCHC Website □ Billboard/Bus Ad □ Brochure/Flyer □ Building Sign □ Business/Agency □ Friend/Family
□ Fair/Festival/Event □ Hospital/Provider □ Internet □ Newspaper/Magazine □ Outreach □ School □ Patient □ TV/Radio

Dear Patient,

In order to continue the variety of services that we offer here at SVCHC and to continue to receive grant funding, we are required to collect the following information on every person that visits our facility. This information is reported as a cumulative number and not reported on individual patients.

Please take a few minutes to complete the following information request:

1. Have you or any family member done agriculturally related work in the last 3 years?
   - ☐ Yes
   - ☐ No

2. If yes, was it migrant farm work in which you travel from town to town without establishing a permanent residence?
   - ☐ Yes
   - ☐ No

3. If yes, was it seasonal farm work in which you travel and work seasonally and have an established residence in the same area?
   - ☐ Yes
   - ☐ No

4. Are you Homeless?
   - ☐ Yes
   - ☐ No

5. If yes, where did you stay/sleep last night?
   - ☐ Homeless shelter
   - ☐ Transitional Housing
   - ☐ Street
   - ☐ Car or other Vehicle
   - ☐ Other
   - ☐ Hotel/Motel
   - ☐ Unknown

6. You have the right to request to be contacted at a different location or by a different method.

SVCHC will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, please provide the contact information below:

_____

Street Address City State Zip Code

Alternative Telephone: _____

Thank you for providing this information to SVCHC. This will ensure that we are able to provide you with valuable services and programs in the future.

SVCHC FO Staff Initials:_____

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Patient Identifying Label

CONSENT TO TREATMENT:
I hereby request and consent to diagnostic procedures, tests, and medical treatment, family planning, birth control methods, and immunizations as deemed advisable by the professional staff of Sonoma Valley Community Health Center (SVCHC). I am aware that a Physician or a Nurse Practitioner may provide the medical care. Services will be in my best interest, or the best interest of my child or legal charge. I understand that this consent to treatment will be in effect as long as I am seen at any of the Sonoma Valley Community Health Center clinic sites. I may cancel this consent in writing.

Signed: **X**_____ _____
Patient Signature/Parent/Legal Guardian Signature (Please circle one) Date

Please print full name and relationship to patient if the patient cannot sign this document.

_____
Full name (print) Relationship

AUTHORIZATION FOR MEDICAL RECORDS RELEASE/REFERRAL AND ASSIGNMENT OF BENEFITS:
I authorize SVCHC to release medical/social information to persons or agencies directly concerned with and engaged in carrying out a treatment plan for the patient. Also SVCHC may use and release any part of my medical records necessary to the process of billing third party payors for services rendered on my behalf. I clearly understand that all my information will be kept confidential. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution.

I authorize payment directly to Sonoma Valley Community Health Center for all medical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. Overpayments on any Sonoma Valley Community Health Center account may be applied to my patient balance. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed: **X**_____ _____
Patient Signature/Parent/Legal Guardian Signature (Please circle one) Date

Please print full name and relationship to patient if the patient cannot sign this document.

_____
Full name (print) Relationship

PROTECTED HEALTH INFORMATION DESIGNEE:
I understand that the individuals identified below will be treated by Sonoma Valley Community Health Center as individuals involved directly in my care or my child's care, and as such SVCHC will be allowed to release the patient's personal health information to these individuals for the purpose of treatment including making appointments and all other functions normally associated with individual patient care, payment, and health care operations.

Name of Designee: _____ Designee Date of Birth: _____

Designee Phone Number: _____ Relationship to Patient: _____

Name of Designee: _____ Designee Date of Birth: _____

Designee Phone Number: _____ Relationship of Patient: _____

☐ *I decline to provide a protected health information designee contact for myself or my child at this time.*

Patient Signature/Parent/Legal Guardian_____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:
I acknowledge that I received the Notice of Privacy Practices from Sonoma Valley Community Health Center.

Signed: **X**_____ _____
Patient Signature/Parent/Legal Guardian Signature (Please circle one) Date

Please print full name and relationship to patient if the patient cannot sign this document.

_____
Full name (print) Relationship