Hyndman Family Health Center
144 5th Avenue
Hyndman, PA 15545
814.842.3206 (P)
814.842.3746 (F)

Bedford Family Health Center
104 Railroad Street
Bedford, PA 15522
814.263.5804 (P)
814.842.3746 (F)

Richland Family Health Center
214 College Park Plaza Suite 208
Johnstown, PA 15904
814.842.3206 (P)
814.842.3746 (F)

# Occupational Health

| 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<br>IF YES, PLEASE LIST: | ETHNICITY (CIRCLE ONE) ☐ HISPANIC ☐ LATINO ☐ OTHER ☐ UNREPORTED/REFUSED<br>VETERAN (CIRCLE ONE) ☐ YES ☐ NO |
|---|---|
| | |

| 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 | | | |
| | | | |

Annual Salary: ☐ $0 - $12,490 ☐ $12,490 - $24,980 ☐ Over $24,980

## ASSIGNMENT AND RELEASE

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 employer and its agents to determine these benefits or the benefits payable for related services.
I understand that I am financially responsible for all charges whether or not to be paid by my employer.

PATIENT'S SIGNATURE PRINT NAME DATE OF SIGNATURE

SIGNATURE OF PARENT/Guardian (MINOR) PRINT NAME DATE OF SIGNATURE