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)									
I A COTT									
LAST		FIRST			MIDDLE MA		AIDEN OR SUFFIX		
ADDRESS									
ADDRESS	GYMY I				T a	m + mm			
PO BOX/STREET		ZIP CODE CITY				S	STATE		
HOME PHONE NUMBER CELL PHONE NUMBER				SOCIAL SECURITY NUMBER				SEX (CIRCLE ONE)	
HOME PHONE NUMBER	NE NOMBER CELL PHONE NOMBER			SOCIAL SECORIT I NOMBER				MALE FEMALE	
								WALL TEWALL	
MARITAL STATUS (CIRCLE ONE) BIRTHDATE				RACE (CIRCLE ONE) WHITE BLACK/AFRICAN AMERICAN					
JIMINITED STATES (CINCELL STALL)				WILL (CIRCLE ONE) WHITE BENCHMARKENIA MILKENIA					
SINGLE MARRIED WIDOWED					AMERICAN INDIAN ALASKA NATIVE HISPANIC				
DIVORCED SEPARATED ASIAN PACIFIC ISLANDER UNREPORTED/REFUSED									
ALLERGIES (PLEASE CIRCLE ONE): YES NO ETHNICITY (CIRCLE ONE) HISPANIC								LE ONE) HISPANIC	
IF YES, PLEASE LIST:							`	,	
				LATINO OTHER UNREF			UNREPORTED/REFUSED		
				VETERAN (CIRCLE			E ONE) YES NO		
		EME	RGENCY CONT	ACT INF	ORMATION				
CONTACT NAME		RELATION	ISHIP	HOME P	HONE NUMBER		CELL PH	HONE NUMBER	
SECOND CONTACT NAME		RELATIONSHIP		HOME PHONE NUMBER			CELL PHONE NUMBER		
PATIENT'S EMPLOYMENT INFORMATION									
OCCUPATION				EMPLO	YER'S NAME				
EMPLOYEDIG ADDDEGG									
EMPLOYER'S ADDRESS			NE I	CITY				COTT A TENE	
STREET		ZIP CODE		CITY			STATE		
EMPLOYER'S PHONE NUMBER									
ENITED LEK STRONE NUNDEK									
h 101 ho 010 100 ho 020 ho 020 100 ho 020 h									
Annual Salary: \$0 - \$12,490 \$12,490 - \$24,980 Over \$24,980									
		AS	SIGNMENT.	AND RI	ELEASE				
I give permission for treatment an	d reques					my behalf	to the Hy	ındman Area Health	
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.									
ĺ	-		-						
DATIENTE CICNIATURE			DD INITE NI AN ATT				ъ.	TE OF CIONATURE	
PATIENT'S SIGNATURE PRINT NAME					DATE OF SIGNATURE				
SIGNATURE OF PARENT/Guardian (MINOR) DDIN'T NAME							D.4	TE OF SIGNATURE	
SIGNATURE OF PARENT/Guardian (MINOR) PRINT NAME					DATE OF SIGNATURE				