HAHC, INC.
OCCUPATIONAL
HEALTH CENTER
A Division of Bedford Family Health Center

104 Railroad Street
Bedford, PA 15522
Phone: 814-709-9803
Fax: 814-310-5497

OCCUPATIONAL HEALTH REGISTRATION

DEMOGRAPHICS

LAST NAME	FIRST NAME	MIDDLE	MAIDEN OR SUFFIX
STREET ADDRESS/PO BOX/APARTMENT #	CITY	ZIP AND STATE	DATE OF BIRTH MM/DD/YYYY
HOME PHONE NUMBER ( )	MOBILE PHONE NUMBER ( )	SOCIAL SECURITY NUMBER	SEX AT BIRTH ☐ FEMALE ☐ MALE
EMAIL			
RACE ☐ WHITE ☐ BLACK/AFRICAN AMERICAN ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN ☐ CHOOSE NOT TO DISCLOSE ☐ OTHER_____			
ETHNICITY ☐ NOT HISPANIC/LATINO ☐ HISPANIC/LATINO ☐ MEXICAN ☐ CHOOSE NOT TO DISCLOSE ☐ OTHER_____			

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPERATED ☐ WIDOWED	VETERAN ☐ Yes ☐ No	PUBLIC HOUSING ☐ Yes ☐ No	HOMELESS ☐ Yes ☐ No	MIGRANT WORKER ☐ Yes ☐ No	SEASONAL WORKER ☐ Yes ☐ No

EMERGENCY

CONTACT NAME	RELATIONSHIP	HOME PHONE NUMBER ( )	MOBILE PHONE NUMBER ( )
SECOND CONTACT NAME	RELATIONSHIP	HOME PHONE NUMBER ( )	MOBILE PHONE NUMBER ( )

EMPLOYMENT

OCCUPATION	EMPLOYER	EMPLOYER PHONE NUMBER ( )
EMPLOYER STREET ADDRESS/PO BOX	EMPLOYER CITY	EMPLOYER ZIP AND STATE
POINT OF CONTACT NAME	POINT OF CONTACT TITLE	POINT OF CONTRACT PHONE NUMBER ( )

PHARMACY

PHARMACY NAME		PHARMACY TELEPHONE NUMBER ( )
PHARMACY STREET ADDRESS/PO BOX	PHARMACY CITY	PHARMACY ZIP AND STATE

ASSIGNMANT AND RELEASE

This form gives authorization for treatment and payment to Hyndman Area Health Center, Inc. (HAHC) for services rendered. This form allows HAHC to release personal health information to my employer (prospective or current), and/or the employers insurance to determine benefits payable for services rendered. I understand that I am financially responsible for all services rendered if not paid by my employer.

_____ _____

Patient Signature Date