



Hospital Emergency Room Alternatives Program Health Interest Form

Name: _____

Date of Birth: _____ Sex: _____

Home Address: _____

Street: _____

City/State: _____

County: _____

Phone Number: _____

Alternate Phone Number: _____

Best time to contact you? 8:00 a.m. – 5:00 p.m. After 5:00 p.m.

INSURANCE INFORMATION: Do you have insurance? Yes No

If yes, who is your Insurance Carrier: _____

NOTES:

My signature certifies I am interested in accessing the Duval County Health Department Network.

Signature

Date