Medical Clinic 605-367-8793
FAX 605-367-8247–Medical Records
FAX 605-367-8211–Nursing

Dental Clinic 605-367-8022
FAX 605-367-8001

City of Sioux Falls
TTY/Hearing Impaired 605-367-7039

Falls COMMUNITY HEALTH

521 North Main Avenue
Sioux Falls, SD 57104
www.siouxfalls.org

SCHOOL-BASED—PATIENT INFORMATION

☐ **Hawthorne** ☐ **Hayward** ☐ **Terry Redlin**

Social Security Number: _____

Patient Name: _____
First Middle Initial Last

Date of Birth: _____ **If under 18:** Mother: _____ Father: _____

Gender: ☐ Male ☐ Female

Address: _____
Street Apt. No. City State Zip

Direct number to reach you at, cell or home: _____ Email Address: _____

Marital Status: ☐ Single ☐ Life Partner ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Where would you like your prescriptions called to?_____

Do you speak English? ☐ Yes ☐ No If **no**, what language do you speak? _____

Are you: ☐ Migrant ☐ Seasonal agricultural worker **Do you have a regular place to stay?** ☐ Yes ☐ No

Where did you spend last night? ☐ Home ☐ Shelter ☐ Street ☐ Hospital ☐ Jail/Prison ☐ Friend
☐ Relatives ☐ Detox ☐ Other _____

Race:
☐ American Indian/Alaska Native
☐ Asian
☐ Black
☐ Native Hawaiian
☐ Hispanic or Latino (all races)
☐ Other Pacific Islander
☐ White (not Hispanic or Latino)
☐ Other (please specify): _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino **Veteran:** ☐ Yes ☐ No ☐ Unknown

What country are you from? ☐ United States ☐ Other _____

Emergency Contact Person: _____

Emergency Contact Phone: _____

♦♦**Has anyone in your family been here before? ☐ Yes ☐ No**

If **yes**, under what name? _____

Please sign back of form.

Responsible Party: _____
(Head of Household/Guarantor) First Middle Initial Last

Please complete table for all people in home:

Last Name, First Name	Relationship to Responsible Party (Head of Household)	Birth Date	Age

Do you have: ☐ Insurance; ☐ Medicare; ☐ Medicaid. Policy Number: _____
(copy card)

Do you qualify for the Free and Reduced Lunch? If yes, please initial below:

_____ I give consent for the release of my household income from the Free and Reduced Lunch application to Falls Community Health for the purpose of determining sliding-fee discounts for medical and/or dental services, or for federal data reporting requirements.

*Refusal to consent to this release will not affect eligibility in the Free/Reduced Lunch Program.

I agree that I am responsible for payment of all services provided by FCH either through Medicaid, Medicare, insurance, or by self-pay sliding-fee based on income. I understand that this consent applies to <u>all services</u>.

_____ _____
Signature Date

NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please print name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Refused to sign; ☐ Communications barrier; ☐ An emergency situation; ☐ Other (please specify)