



General Patient Information



Community Health Clinic

Alcester Medical Center

Section A

Patient Name: _____
Last First Middle Initial

Mailing Address: _____
Apt# City State Zip Code

Physical Address: _____
Apt# City State Zip Code

Phone Number: (home) _____ (work) _____ Date of Birth: _____
(Parent if minor child)

Social Security Number: _____ Employer _____

Employer Address: _____ Employer Phone: _____

Marital Status: Single Single with Partner Married Divorced Separated Widowed
(please check appropriate box)

Emergency Contact: _____ Relationship to Patient: _____
First Name Last Name

Emergency Contact Phone No.: _____

Section B

The following information is being collected for Federal reporting purposes:

Sex: Male Female Are you a Veteran of the US Military: Yes No

Ethnicity: Not Hispanic / Latino Hispanic / Latino

Race: American Indian / Alaska Native Other Pacific Islander
 Asian White (not Hispanic or Latino)
 Black / African American Unreported / Refused to Report
 Native Hawaiian

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

Housing: Doubling Up Other Unknown Student Status: Full time
 Homeless Shelter Street Part time
 Not Homeless Transitional (temp housing) None

Are You: Farmer Not an agricultural worker
 Migrant agricultural worker Dependant of Migrant agricultural worker
 Seasonal agricultural worker Dependant of Seasonal agricultural worker

Employment Status: Full time Part Time Unemployed Retired _____
Date



**Elk Point
Community
Health Clinic**
356-3317



Alcester Medical Center
a division of the Union County Health Foundation
104 W 2nd, P.O. Box 468, Alcester, South Dakota 57001
Phone: (605) 934-2122 FAX: (605) 934-1705

Billing Information

Community Health Clinic

Alcester Medical Center

Section A

A-1: If different from patient

Responsible Party: _____
Last First Middle Initial Date of Birth (MM-DD-YYYY)

Billing Address: _____
Apt# City State Zip Code

Phone Number: _____ Business Phone: _____

SSN: _____ Employer: _____

Employer Address: _____
City State Zip Code

A-2: Insured information

Policy Holder: _____ DOB: _____

SSN: _____ Employer: _____

Employer Address: _____
City State Zip Code

Policy Holder
Address if different: _____
Apt# City State Zip Code

You may be eligible for reduced charges at our clinic if your income qualifies. If you have no insurance, have private insurance, or you are on Medicare and do, or do not, have a secondary insurance company, you may qualify

For example, a family of four (4) with an annual household income of \$44,101.00 or less would qualify for reduced fees.

If you have questions or believe you will meet the guidelines, please visit with one of the receptionists to get further information and apply!

For Office Use:

Scan copy of Insurance Card(s) & Drivers License into system.



Elk Point
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Community Health Clinic

HOW CAN WE CONTACT YOU?



Alcester Medical Center

Patient Name: _____

Please list your contact information:

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-Mail Address: _____

IF YOU ARE NOT AVAILABLE, MAY WE SPEAK TO ANYONE ELSE?

(check "√" all that apply)

_____ Please do not speak with anyone but me.

_____ I give my permission to speak with;

First Name	Last Name	Phone Number
_____	_____	_____
_____	_____	_____

First Name	Last Name	Phone Number
_____	_____	_____

_____ You may leave a message on my answering machine/voice mail. *

*If you have an answering machine, we will leave a message to call the clinic.

_____ It is ok to leave appointment reminder message.