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

PATIENT INFORMATION

☐ **Hawthorne** ☐ **Hayward** ☐ **Main Site** ☐ **Terry Redlin**

Patient Name: _____
First Middle Initial Last

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

Gender: ☐ Male ☐ Female Social Security Number: _____

Gender Identity: ☐ Male ☐ Female ☐ Transgender – Male to Female ☐ Transgender – Female to Male ☐ Other

Sexual Orientation: ☐ Lesbian/Gay ☐ Straight ☐ Bisexual ☐ Something Else ☐ Don't Know

Address: _____
Street Apt. No. City State Zip

Phone Number: _____(Home)_____(Cell) Email Address: _____

Emergency Contact Name: _____ Emergency Contact Phone:_____

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

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

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

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

What is your household gross income? ☐ $0-$15,000 ☐ $15,001-$22,000 ☐ $22,001-$30,000 ☐ $30,000+

Do you have a permanent home (house, apartment, etc.)? ☐Yes ☐ No

If no, where did you spend last night? ☐ Shelter ☐ Street ☐ Friends/Relatives ☐ Other_____

Please complete & sign back of form.

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

Please complete table for all people in home:

Last Name, First Name	Relationship to Responsible Party	Birth Date	Health Insurance	Patient at Clinic

Do you have: ☐ Insurance; ☐ Medicare; ☐ Medicaid. Policy Number: _____

****You may be eligible for a discount on services based on your household income. Please contact the front desk or Billing Office for more information.**

Financial Responsibility and Assignment of Payer Benefits

I agree that I am financially responsible for all charges related to services provided by Falls Community Health (FCH). Further, if I am provided health care services by a provider other than FCH, while a patient within FCH, I am financially responsible for all charges related to services provided by said provider. FCH billing statements will not include charges by health care providers independent of FCH.

I agree FCH will bill and provide necessary health information to any Payers. “Payers” are any health care insurance, private or government health plan, or insurance policy that I have or another third party that will pay the charges I have incurred. I give my authorization for FCH to filing of a claim and request for direct payment of benefits to FCH.

Consent to Treatment

I consent to exams, treatments, diagnostic tests, and medications that any provider at FCH feels is necessary for the health of me or my child.

I acknowledge that no guarantees have been made to me and I am aware that I have the right to ask my provider or nurse questions regarding my treatment or exam.

I authorize FCH to disclose my confidential information only for treatment, payments, or health care operations.

I give consent to nursing appraisal, health supervision, immunizations, and release of information as indicated to the school district.

Notice of Privacy Practices

I have been offered a copy of this office’s Notice of Privacy Practices.

Authorization

_____ _____ _____
Signature of Patient or Authorized Person Print Name Date

_____
Relationship to Patient (if patient not signing)