CLINIC PROCESSES, PROCEDURES, & PATIENT RESPONSIBILITIES

Alliance Medical Ministry's goal is to provide you with quality, comprehensive healthcare, and enable you to lead your healthiest lifestyle. **We need you as a partner in this journey.**

Review Clinic Information and Patient Responsibilities below. We require all patients to sign and receive a copy of Patient Responsibility & Accounting Agreement, and Patient Financial Responsibility Agreement, verifying your understanding and agreement of your responsibilities as an Alliance patient.

CLINIC HOURS: Monday- Thursday: 8:30 AM-4:00 PM
Friday: 8:00 AM – 12:00 PM
Closed on holidays

If you go to the Emergency Room, take your purple AMM Patient ID Card with you.

Bring ALL prescription medications to ALL appointments.

Do you take medications **DAILY**? If so, you MUST be seen by a provider **at least twice (2) a year.**

- If needed, we are able to access other specialty care off-site with area physicians.
  - Note: Not all patients qualify
  - ALL tax and financial information is **REQUIRED** to determine eligibility for these appointments AND to schedule appointments.

- We are able to refer patients off-site for dental care at reduced rates. Ask your physicians for more information.

FOR OFFICE USE ONLY
NEW: WAKE DR REX CCC SUP
RECERT/FORMER LAST SEEN: ____/____/______

APPROVED: ____/____/______
BY: ___________________________________

PATIENT INFORMATION FORM

LAST Name: ____

FIRST Name: _________________________ MIDDLE Name: ___________________

MAIDEN Name: ______________________ Birth Date: ___________(mm/dd/yyyy)

Home Address: ____

City: _________________________________ State:____ Zip Code: _____________

SSN/Tax ID: _________________________ VISA/Green Card #: _________________

E-Mail: ____________________________

Primary #: ___________________________ Cell ____ Home ____

Work #: ____________________________

County of Residence (Check One):

___ Durham
___ Harnett
___ Johnston
___ Orange
___ Wake
Other County: ________________

Gender (M/F/Other): ____________________

Marital Status: ___Married ___ Single ___ Divorced ___ Separated ___ Widowed

Race (Check One):

__ American Indian or Alaskan Native
__ Asian
__ Black or African American
__ Caucasian or White
__ Hispanic or Latino
__ Native Hawaiian or Pacific Islander
__ Other: _________________________

Preferred Language: Speaking: ________________ Reading: ___________________

Residency Status (Check One):

__ US Citizen
__ Alien with valid Employment Card
__ Foreign citizen with a valid VISA
__ Foreign student, tourist or business traveler
__ Student Visa
__ Foreign citizen with permanent residency < 5 years
__ Foreign citizen with permanent residency > 5 years
__ Undocumented

What is your current employment status?

___ Full Time ___ Part Time ___ Temp
___ Seasonal ___ Self Employed ___ Unemployed

Employer Name(s): ____

Are you a full-time student? (Yes/No) ___________

If yes, where: ____

When was the last year that you filed a tax return? _______________

Do you receive Social Security or Disability benefits? (Yes/No) __________

If Yes, when did you apply for benefits? ____________________________

When did your benefits begin? ______________________________________

How much do you receive monthly? __________________________________

Veteran Status (Check One):

___ Active ___ Never served
___ Retired ___ Reservist

Have you applied for Veteran benefits? (Yes/No) ___________

If Yes, when did you apply for benefits? ____________________________

When did your benefits begin? ______________________________________

Do you have health insurance? (Yes/No) ___________

If Yes, what insurance do you have?

___ Private insurance (e.g. BCBS, United Healthcare, Cigna, Aetna)
___ Dental care
___ Vision care
___ Medicaid
___ Medicare
___ Other
Please specify: _______________

Is this appointment due to: ___ car accident _____ work-related injury

If yes, please indicate date/type of injury:________________________________

How did you find out about Alliance?

___ Internet
___ Social Media
___ Community Flyer
___ Partner Agency:
___StepUp Ministry
___Family Table
___ Other: ____________________
___ Friend/Family
___ Place of worship: _________________
___ Hospital/Provider Referral:
___WakeMed ___ UNC-REX
___Duke Raleigh _____ Health Dept.
___ Other: _____________________

What kind of transportation do you use to get to the clinic?
___private car
___taxi
___bus
___walk
___other

Emergency Contact Information

Full Name: ____

Relationship to patient: ____

Primary #: _______________________ Work #: _______________________________

Address: ____

City/State/Zip Code: ____

Hospital Use

If you were to go to a hospital, which one would you use:

___ WakeMed   _____UNC Rex   _____ Duke Raleigh   _____ UNC-CH

Your last use of an Emergency Department or Inpatient was at which Hospital:

___ WakeMed   _____UNC Rex   _____ Duke Raleigh   _____ UNC-CH

Additional Household Members

How many people in your household? ____________________

1. Full Name: ________________________________Age: ___ Date of Birth: ________

Is this person employed? (Yes/No) _____ Monthly Income: ___________________

Relationship to Patient: ____

2. Full Name: ________________________________Age: ___ Date of Birth: ________

Is this person employed? (Yes/No) _____ Monthly Income: ___________________

Relationship to Patient: ____

3. Full Name: ________________________________Age: ___ Date of Birth: ________

Is this person employed? (Yes/No) _____ Monthly Income: ___________________

Relationship to Patient: ____

4. Full Name: ________________________________Age: ___ Date of Birth: ________

Is this person employed? (Yes/No) _____ Monthly Income: ___________________

Relationship to Patient: ____

Please list any others in available space below/back: