



ALLIANCE MEDICAL MINISTRY

Standard Application

Last Name: _____

First Name: _____ Middle Name: _____

Maiden Name: _____ Birth Date: _____ (MM/DD/YYYY)

SSN/Tax ID: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Relationship to Head of Household: _____

Date of Application: _____

How were you referred to this clinic? _____

Gender: _____ Marital Status: Single Divorced Widowed Married Separated

Race: (You can choose up to two options)

- American Indian or Alaska Native
- Asian
- Black or African America
- Caucasian/White
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- Other

Housing Status: Homeless Renting Home Owner

How many years of school did you complete? (1-20) _____

What is the highest degree you have obtained? High School Diploma College Masters

Are you a full-time student at a 4-year college or university? _____

What is your preferred language for speaking? _____ Reading? _____

Language(s) you read and write? _____

Disabled: Yes No **Veteran:** Active Retiree Veteran Civilian **Applied for VA benefits:** Yes No

Residency Status: (check one)

_____ 72 hour boarder crossing card

_____ Alien with valid employee card

_____ Perm resident less than 5 years

_____ Perm resident greater than 5 years

_____ Student/ Tour/ Bus Traveler

_____ US Citizen

_____ Undocumented

Insurance: Do you have insurance?: Yes No

If so which insurance do you have?

_____ Blue Cross Blue Shield

_____ Cigna

_____ Medicaid

_____ Medicare

_____ NC Health Choice

_____ Humana

_____ MedCost

_____ United

Emergency Contact

(Full Name)

(Relationship to Patient)

(Street Address)

(Home Phone)

(City, State, Zip Code)

(Work Phone) / (Cell Phone)

Additional Household Members

How many household members are in your home INCLUDING YOURSELF? _____ (Include all adults and all minors.)

Please list the Name, Date of Birth and Relationship of all household members below:

Full Name
Is this person employed? _____ Yes _____ No

Date of Birth
Relationship to Patient

Full Name
Is this person employed? _____ Yes _____ No

Date of Birth
Relationship to Patient

Full Name
Is this person employed? _____ Yes _____ No

Date of Birth
Relationship to Patient

Full Name
Is this person employed? _____ Yes _____ No

Date of Birth
Relationship to Patient

Full Name
Is this person employed? _____ Yes _____ No

Date of Birth
Relationship to Patient

Full Name
Is this person employed? _____ Yes _____ No

Date of Birth
Relationship to Patient

