Patient Intake Form

Date:

Nhan Hoa Comprehensive Health Care Clinic Inc. "Nhan Hoa Health Center" is a Federally Qualified Health Center and all information requested is for statistical purposes. All information is strictly confidential to the full extent permitted by law. No identifying information will be released without your consent. The information requested allows Nhan Hoa Health Center to evaluate each client for eligibility for our programs; therefore, we request you complete this document in its entirety.

FIRST NAME:	**MIDDLE NAME:**	**LAST NAME:**

Address:	**City:**	**Zip Code:**

Main Phone Number:	**Other Phone Number:**	**Email:**	**Date of Birth:**

Social Security # (Optional):	**Birth State/Country:**	**Homeless:** **Agriculture Worker:** **US Veteran:**
		__Yes __No __Yes __No __Yes __No

Preferred Methods of Contacts:	**Marital Status:**
Telephone__ Email__ Mail__	Single:__ Married: __ Divorced:__ Other:_____
Health Insurance:	**Do you have Advance Directive?**
__None/Self Pay __Medicare __ Medicaid __PPO __HMO	__Yes __No __Request more info

Sexual Orientation:	**Gender Identity:**	**Race:**	**Ethnicity:**	**Primary Language:**
__Heterosexual __Homosexual __Bisexual __Transgender __Other	__Male __Female __Transgender M-F __Transgender F-M __Other	__Asian __Black/African American __White __Native Hawaiian __Am. Indian/Alaska Native __Pacific Islander __Multiracial	__Hispanic __Non Hispanic	__English __Spanish __Vietnamese __Other:_____ (Specify)

Family Size:	**Total Family Household Income per Month:**
	_____ /per month

Do you have any allergies? __No __Yes (Please List):	
Are you currently taking any medication? __No __Yes (Please list):	

Emergency Contact		
Name:	Relationship:	Phone Number:
How did you learn about our services?		
__Friend/Relative __In Print __ On Radio/TV __ Internet __ Referral __ Community Event __Other		

Terms of Consent

By signing below, I agree to the terms and information above. I am giving this consent of my own free will. I fully release Nhan Hoa Health Center as well as their Officers, Directors, Board Members, employees, and agents (i.e.: volunteers, students) harmless from any and all damages, losses, liabilities (joint or several), payments, obligations, penalties, claims, litigation, demands, defenses, judgments, suits, proceedings, costs, disbursements or expenses (including without limitation, fees, disbursements and expenses of attorney, and other professional advisors and of expert witnesses and costs of investigation and preparation) of any kind or nature whatsoever resulting from, relating to or arising out of my receipt of services. I have had the opportunity to ask any questions and have had them answered in a language that I understand. I further agree to abide by the terms of this consent. I understand that this document remains in effect until I revoke my consent in writing. I also understand that I am free to revoke my consent at any time.

Patient's or Guardian's Name (Print)	**Patient's or Guardian's Signature:**	**Date:**