



Sexual Health Clinic Intake Form

PLACE LABEL

Information disclosed below allows the SNHD to determine needs/resources for you and the health needs of our community. All information is confidential.

For minors: You can receive services at the Family Planning Clinic/Sexual Health Clinic without parents' permission.

How did you hear about our services?

Language most comfortable speaking: _____ **Do you need an interpreter?** Yes No

Hearing impaired or need sign language interpreter services? Yes No

Emergency Contact:

Relationship:

Phone Number:

WE CARE ABOUT YOUR PRIVACY.

We offer confidential services to all our clients. This means we will not release information about your visit to a friend, parent, guardian or relative without your permission.

INFORMATION NECESSARY TO RECEIVE CONFIDENTIAL INFORMATION (test results, etc) ON THE PHONE:

Mother's Maiden Name: _____ Password: _____

Income Information

Are you currently enrolled in Ryan White Services? Yes No **Where?** _____

I have no income I am unemployed I am homeless

Total Household Monthly Income	\$
Total Number of People in Household	

Consent for Medical Treatment

I give my consent to the medical staff of the Southern Nevada Health District's Clinical Services Programs/Clinics to examine, obtain necessary lab work, treat and counsel me or my child. I understand that there are certain hazards and risks connected with all forms of treatment and care, and with this knowledge, I give my consent. I understand that if I am treated for or diagnosed with a sexually transmitted infection the clinic is required by law to report this to certain public health agencies. I understand that clinic staff may also be required by law to report some claims of physical or sexual abuse. I hereby certify that I have read and fully understand the above consent for testing and/or treatment. After evaluation, if my medical condition is beyond the capacity of SNHD services, I will be referred elsewhere for further care.

I have answered all the questions correctly to the best of my knowledge.

_____ **Print Name of Client**

_____ **Signature**

_____ **Date**

I ACKNOWLEDGE THAT I HAVE RECEIVED THE "NOTICE OF PRIVACY PRACTICE." _____ **(Initial)**