# 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 us: ☐ Previous Patient ☐ Friend/Relative ☐ Online ☐ Referral ☐ Health Fair ☐ Facebook ☐ Twitter ☐ SNHD Website ☐ Other _______________

Language most comfortable speaking: ___________________ Do you need an interpreter? ☐ Yes ☐ No

Hearing impaired or need sign language interpreter services? ☐ Yes ☐ No

Would you like assistance locating resources (for example, Medicaid, dental care, food assistance)? YES ☐ NO ☐

IF YES, explain:

Emergency Contact(s): ___________________________________ Phone: ____________________

Relationship: ☐ Parent ☐ Guardian ☐ Spouse ☐ Other

**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: ____________________________

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

## Income Information

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

☐ I decline to release any income information and accept the cost of non-discounted services.

☐ I have no income ☐ I am unemployed ☐ I am homeless

| | |
|---|---|
| What is **your** weekly **income before taxes**?<br>Hourly rate of pay _______ Number of hours you work per week _______ | |
| What is your partner/spouse's weekly income **before taxes**?<br>Hourly rate of pay _______ Number of hours you work per week________ | |
| Any other income (Tips, SSI, etc.) to report? ☐ Yes ☐ No<br>List type and amount: | |
| **If you do not have income, please explain how your basic needs are paid for:** | |
| Total Household Weekly Income? | |
| Total Number of People in Household? | |

**Office Use Only**

Sliding fee category: ____
Reviewed by: __________

Referred for Hardship:
Date: ______________
Initials: ____________

Ref. to EW re services:
Date: ______________
Initials: ____________

## 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** **Signature** **Date**

**Relationship:** ☐ **Self** ☐ **Parent** ☐ **Guardian** ☐ **Other** ____________________________

Approved 9-25-2018 FL/JR

Staff Initials/Date _____________