Patient Intake Form

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.

Name: _____ **DOB**:_____
First Middle Initial Last *MM/DD/YYYY*

Address: _____
Street Address City State Zip

Home Phone: _____ **Cell Phone**:_____ **Email**: _____

Driver License State & Number (please attach a copy): _____

Gender at Birth: ☐Male ☐Female **Family Size**: _____ **Total Income**: $_____/month

Insurance? ☐Medicare ☐Medi-Cal ☐Medi-Medi ☐PPO ☐HMO ☐None/Self Pay **Ins. Name**:_____

Emergency Contact: _____ **Relationship**: _____ **Phone**: _____

Marital Status:	Sexual Orientation:	Gender Identity:	Primary Language:	Race (check all that applies):	Ethnicity:
☐ Single ☐ Married ☐ Divorced ☐ Other (specify):	☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Don't Know ☐ Choose Not to Disclose	☐ Male ☐ Female ☐ Transgender M-F ☐ Transgender F-M ☐ Queer ☐ Choose Not to Disclose ☐ Other:_____	☐ English ☐ Spanish ☐ Vietnamese ☐ Other (specify):	☐ Asian ☐ Black/African American ☐ White ☐ Native Hawaiian ☐ Am. Indian/Alaska Native ☐ Pacific Islander ☐ Multiracial	☐ Hispanic ☐ Non Hispanic

CONSENT

When I enter Nhan Hoa, its events or programs, I enter an area where photography, audio, and video recording may occur. By entering its premise, I grant Nhan Hoa non-revocable permission to capture my image and likeness in photographs, videotapes, motion pictures, recordings, or any other media. I further waive all rights I may have to any claims for payment or royalties in connection with any use or other publication of these materials, regardless of the purpose. I also waive all rights to inspect or approve any photo, video, or audio recording taken by Nhan Hoa or the person or entity designated to do so by Nhan Hoa.

By signing below, I agree to the terms and conditions stipulated above. I also hereby authorize Nhan Hoa to provide reasonable and proper confidential medical care and treatment, which may be rendered by physicians, nurse practitioners, physician assistants, or other medical professionals in training (under the supervision of a licensed medical professional). 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 also grant Nhan Hoa non-revocable permission to capture my image and likeness in photographs, videotapes, motion pictures, recordings, or any other media. 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 Signature *Date*

_____ _____
Parent or Guardian Name *Parent or Guardian's Signature* *Date*