Name (Nombre) _____
Date of Birth (Fecha de Nacimiento) _____
Time Arrived (Hora de llegada) _____

Office Use Only
Para el uso de la oficina Solamente
Place Client Label Here

SAMHD STD/HIV CLINIC INTAKE ASSESSMENT

(Para español, por favor vea el otro lado de esta hoja)

To provide the best service to you, please answer ALL questions below.

1.) Have you been here before? __No __Yes If yes, when was the last time?_____

2.) Did someone tell you to come in today?

- o No
- o Yes, for Chlamydia or Gonorrhea
- o Yes, for Syphilis
- **If yes, then please tell us who asked you to come in:**

____Staff member from our clinic; Name:_____
____Partner; Name:_____,DOB:_____
____Other:_____

- If your partner told you to come in today, mark which infection **they** are diagnosed with:
  - o Chlamydia
  - o Gonorrhea
  - o Syphilis
  - o HIV or AIDS
  - o Trichomoniasis
  - o I'm not sure which infection
  - o Other(Please explain)_____

3.) Are you having Symptoms TODAY? (If yes, please check all boxes that apply & fill in blanks below)

- o No
- o Pain while urinating
- o Discharge or Drip that is (circle all that apply) clear/ white / yellow / green
- o Discharge or Drip that is bloody
- o Itching: Where?_____
- o Rash: Where_____
- o Pain: Where?_____
- o Sores(s), Lesion(s), Blister(s), Wart(s), or Bump(s)
- o Other:_____

4.) Are you here with your partner? __No __Yes
(Partner's Clinic number:____)

5.) Are you pregnant? __No __Yes

6). Risk Assessment

In the past 90 days, have you:

□ Had sex with someone you did not know?
□ Had sex with someone you met on line/ on the internet?
□ Exchanged sex for money or drugs?
□ Had sex with prostitutes (male or female)?
□ Used drugs like crack cocaine, crystal meth, or other IV drugs?
□ Been told that one of your sex partners has syphilis /HIV?

For Men

In the past 90 days, have you:

Had sex with other men? __No __Yes
Had sex in a public place like a bathhouse, book store, parking lot? __No __Yes
*When the forms have been completed please wait for your number to be called. Thank you!

Demographics Form (Forma Demografica) #2 Rev. 01-17-14

WELCOME TO THE SAN ANTONIO METRO HEALTH DISTRICT STD/HIV CLINIC

Bienvenido a la clincia de ETS/VIH del districto de salud de la zona metropolitana de San Antonio.
Please complete this form and return it to the Registration Clerk.
Por favor llene la forma y regreselo al escritorio de registro.
Please print letters clearly. Por favor escribir letras de molde.

Date of Birth (Fecha de nacimento)	**Social Security Number** (Numero de Seguro Social)	
First Name (Nombre)	**Middle Name** (Segundo Nombre)	**Last Name** (Apellido)
What other names have you used in the past? (Que otros nombres usted hay utilizado en el pasado?)		
Street Address (Direccion)		**Apt #** (# Apartamento)
City (Ciudad)	**State** (Estado)	**Zip Code** (Codigo Postal)
Telephone # (# Telefono)	**Cell Phone** (Telefono cellular)	**Email Address** (Correo electronico)

Your Education (Su Educacion) **circle highest grade completed** (Encierre en un círculo el grado mas alto completado)

1 2 3 4 5 6 7 8 9 10 11 12

☐ GED ☐ Some College ☐ Associate's Degree ☐ College Graduate ☐ Post Graduate Degree ☐ In School

Race (Raza) ☐ White (Blanco) ☐ African-American/Black (Afro-Americano) ☐ Asian (Asiatico) ☐ Pacific Islander (Isleno Pacifico) ☐ Native American (Americano Nativo) ☐ Multiple (Varias) ☐ Other (Otro)	**Ethnicity** (Etnicidad) ☐ Hispanic (Hispano) ☐ Non-Hispanic (No-Hispano)	**Sex/Gender**(Sexo/Genero) ☐ Male (Hombre) ☐ Female (Mujer) ☐ Transgender (trans sexual) (M-F) ☐ Transgender (trans sexual) (F-M)
Marital Status (Estado civil) ☐ Single (Soltero) ☐ Married (Casado) ☐ Divorced (Divorciado) ☐ Separated (Separado) ☐ Widowed (Viudo) ☐ Partner(Companero)	**Primary Language** (Idioma Preferida) ☐ English (Ingles) ☐ Spanish (Espanol) ☐ Other (Otra): _____	**Do you have health insurance?** ☐ No (No) ☐ Yes (Si) **If Yes, is your insurance:** **Medicaid?** ☐ No (No) **CHIP?** ☐ Yes (Si)

Family Size In Persons (Numero de personas en su hogar):

Total Monthly Household Income Before Deductions (Total Ingresos Mensuales Antes de Deducciones):

AMOUNT(Cantidad): ☐ **Weekly** (Por Semana) ☐ **Bi-Weekly** (Cada Dos Semanas) ☐ **Monthly** (Por Mes)

Name of Emergency Contact (Nombre de la persona en caso de emergencia)	Emergency Contact Phone # (# de telefono de la persona)	Relationship to you (Relacion a usted)

Are you Pregnant? (Esta embarazada?) ☐ Yes/Si ☐ No/No ☐ Does not apply	**When is the last time you were at this clinic?** (Cuando Fue la ultima vez que usted estuvo en esta clinica?)

For Official Use Only
NTST #:

MIS / Sys #

SAN ANTONIO METRO HEALTH DISTRICT
Please complete this form and return it to the Registration Clerk.

Patient Financial Information

Family Size (Number of People, including yourself)	**For Payment today:**
□ 1-Me □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ _____	□ No-Insurance □ I have Insurance

No Insurance - For Payment Out-of-Pocket

*SAMHD utilizes the Sliding Scale Fee Payments for non-insured patients. If you do not have insurance, your bill will be a percentage calculation based on your household income and household size. Please complete the section below for your **payment discount** off of your visit bill.*

Family Incomes *(Earnings of any of the people that live with you, including teenagers. Earning is any incoming money, including government assistance, child support payments, etc.)*

#1)	**Family Members First Name**	**Income Amount** $	**Period of Earnings** □ Annual □ Bi-Weekly □ Monthly □ Weekly
	Is this Employment Income? □ No □ Yes	**Who is the Employer?**	
#2)	**Family Members First Name**	**Income Amount** $	**Period of Earnings** □ Annual □ Bi-Weekly □ Monthly □ Weekly
	Is this Employment Income? □ No □ Yes	**Who is the Employer?**	
#3)	**Family Members First Name**	**Income Amount** $	**Period of Earnings** □ Annual □ Bi-Weekly □ Monthly □ Weekly
	Is this Employment Income? □ No □ Yes	**Who is the Employer?**	
#4)	**Family Members First Name**	**Income Amount** $	**Period of Earnings** □ Annual □ Bi-Weekly □ Monthly □ Weekly
	Is this Employment Income? □ No □ Yes	**Who is the Employer?**	

I have no household income, and I am currently unemployed _____ **Initial Here**

Insurance Information

Name of Insurance Company/Insurance Plan

Is your Insurance:	**Insurance Policy #:**	**Copay Amount** (if applicable)
□ Medicaid □ Medicare □ Private Insurance		$

Effective Date (Term Beginning)	**Effective Through** (Term End)	**Group Number** (if applicable)
/ /	/ /	