Lyon-Martin Health Services
Patient Intake Information

Date: _____

Preferred Name: _____

For billing purposes, if you have insurance, what gender do they have on record for you? ☐ Female ☐ Male

Name as it appears on your insurance card: _____

Home Address : _____

City: _____ State: _____ Zip Code: _____

Mailing Address (***if different from Home Address***): _____

City: _____ State : _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Email Address: _____

Can we leave you a confidential message at these phone numbers? Yes No

Date of Birth: _____ SSN: _____-_____-_____

Emergency Contact: _____ Relationship: _____

Phone Number: _____

My preferred language is: ☐ English ☐ Spanish ☐ Other: _____

If you don't have contact information, what other social service agencies do you frequent?

_____

What type of Insurance(s)/coverage(s) do you have? ***We treat everyone regardless of ability to pay.***

☐ None ☐ CDP/EWC ☐ Medi-Cal ☐ Medicare ☐ San Francisco Health Plan Medi-Cal

☐ Healthy SF ☐ Family Pact ☐ Anthem Blue Cross Medi-Cal ☐ Other: _____

We must collect ALL patients' income information in order to stay in compliance with Federal Regulation, as Haight-Ashbury Free Clinics is a Federally Funded Community Health Clinic. (Even if you have insurance).

What is your source of income?

☐ Full time employment ☐ Part-time Employment ☐ SSI ☐ Disability/SSDI

☐ General Assistance/GA ☐ Unemployment benefits ☐ Student Loan ☐ Savings

☐ Money from parents ☐ Money from friends/others ☐ Savings ☐ No income at all

What is your income before taxes? $: _____ each month.

Including yourself, how many people are in your household? _____

Due to federal Regulations, we must ask ALL patients their household size and income, regardless of health insurance status. Household members include those persons living at the same home who are related by birth, marriage, registered domestic partnership, adoption.

Please Complete Backside

My race is:

- ☐ Native American and/or Alaskan Native
- ☐ Hispanic or Latino
- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Native Hawaiian
- ☐ Asian
- ☐ Other Pacific Islander
- ☐ More than one race
- ☐ Other:_____
- ☐ Decline

I am Hispanic/Latino/Latina: Yes No

I am a seasonal agricultural worker: Yes No

I am a migrant worker: Yes No

I am a veteran: Yes No

My living situation now and in the last 12 months (please check all that apply):

- ☐ At risk of becoming homeless
- ☐ Homeless sometime during the last 12 months
- ☐ Sleeping in the park or on the street
- ☐ Residential program or half way house
- ☐ Living in a hotel/SRO (single room occupancy)
- ☐ Living with friend and/or family (I do not pay rent)
- ☐ Homeless
- ☐ Living in a van or car
- ☐ Unstable living situation
- ☐ Staying in a shelter
- ☐ Rent or own room/apartment/house (I pay rent)
- ☐ Other: _____

Check all that apply:

My gender identity is:

- ☐ Woman
- ☐ Man
- ☐ Trans (MTF)
- ☐ Trans (FTM)
- ☐ Genderqueer
- ☐ Other: _____
- ☐ Decline

My sex assigned at birth is:

- ☐ Female
- ☐ Male
- ☐ Intersex
- ☐ Other: _____
- ☐ Decline

My marital status is:

- ☐ Single
- ☐ Widowed
- ☐ Married
- ☐ Unmarried Partner
- ☐ Divorced
- ☐ Legally Separated
- ☐ Registered Domestic Partner
- ☐ Other: _____
- ☐ Decline

My sexual orientation is:

- ☐ Lesbian
- ☐ Gay
- ☐ Queer
- ☐ Bisexual
- ☐ Heterosexual
- ☐ Asexual
- ☐ Other: _____
- ☐ Decline
- ☐ Questioning

My pronoun preference is:

- ☐ She/her
- ☐ He/his
- ☐ They/Them/Their
- ☐ Zie/Hir
- ☐ Other: _____

Patient Signature: _____ Date: _____

Parent of Guardian Signature: _____Date:_____

A parent or guardian must sign if the patient is under 18 years of age but not if the patient is an emancipated minor