In order to submit this form, you should open it with Adobe Acrobat Reader.

Damien Ministries Client Intake

NAME: *

First Name Last Name

ADDRESS: *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

PHONE NUMBER: *

Area Code Phone Number

SOCIAL SECURITY NUMBER: *

EMAIL ADDRESS: *

example@example.com

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DATE OF BIRTH: *

Month Day Year

CURRENT GENDER *

- Male
- Female
- Transgender Unknown
- Transgender M-F
- Refuse to report
- Transgender F-M

RACE: Check all that apply *

- White
- Black/African american
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Vietnamese
- Korean
- Other Asian
- Native Hawaiian
- Guanamalian
- Samoan
- Other Pacific Islander
-

ETHINICITY: *

- Non Hispanic
- Hispanic
-

MARITAL STATUS *

- Married
- Single

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- [ ] Widowed
- [ ] Divorce
- [ ] Seperated

TOTAL NUMBER OF CHILDREN UNDER 18: *

LIST NAMES AND AGES OF ALL CHILDFREN IN HOUSEHOLD:

SOURCE OF INCOME: *

HEALTH INSURANCE: (Name/Policy Number if applicable)

REASON FOR VISIT: *

- [ ] Food bank
- [ ] Case management
- [ ] BOCA
- [ ] Prep/Pep Services
- [ ] HIV Testing
- [ ] HCV Testing
- [ ]

HIV STATUS: *

- [ ] HiV Postive not AIDS
- [ ] HIV Positive AIDS Status
- [ ] CDC defined AIDS
- [ ] HIV Negative
- [ ] Unknown

HIV RISK Factors/Transmission Category(check all that apply) *

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- [ ] male who has sex with male(s)
- [ ] blood transfusion/blood products
- [ ] parinatal transmission
- [ ] _____

PHYSICIAN NAME

First Name Last Name

PHYSICIAN WORK ADDRESS

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

PHYSICIAN PHONE NUMBER:

Area Code Phone Number

APPOINTMENT DATE:

Month Day Year

Time

Hour Minutes

WAS VERIFICATION OF HIV STATUS PRESENTED?

- [ ] yes
- [ ] no

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STAFF MEMBER REVIEWING INTAKE:

REFERRAL DATE & SOURCE:

EMERGENCY CONTACT INFO:

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