Kheir Clinic
이웃케어클리닉
Clínica Kheir

NEW PATIENT INTAKE FORM

All information listed is completely confidential. Please note, the form is double-sided.

Patient Information:	**Today's Date:** ____ /____ /_____
Name (Last, First, M.I.):	
Date of Birth:	Social Security Number:
Sex at birth: ☐ Male ☐ Female	Identified Gender: ☐ Same as birth ☐ Trans Male ☐ Trans Female ☐ Other ☐ Decline to state
Sexual Orientation: ☐ Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Something else ☐ Don't know ☐ Decline to state	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed U.S.	
Veteran: ☐ Yes ☐ No ☐ Decline to state	Disabled: ☐ Yes ☐ No
Address:	
City:	State: Zip Code:
Family Size (including yourself):	Gross monthly household income: $
Residence Type: ☐ Own/Rent ☐ Staying with friends ☐ Temporary ☐ Homeless ☐ Other:	
Preferred Communication: Please check all contact methods in which you would like to be contacted for your health	
☐ Home Phone	☐ Mobile Phone:
☐ Email:	
☐ I DO NOT want to receive electronic communication (text & email) regarding my care.	

Race: Please check all that apply. (Required by the Federal Government)

☐ Korean ☐ White ☐ Black/African ☐ Bangladeshi ☐ Thai ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Vietnamese
☐ Other Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Guamanian ☐ Samoan ☐ American Indian/Alaska Native
☐ Other:

Ethnicity: (Required by the Federal Government)

☐ Non-Hispanic
☐ Mexican ☐ Mexican American (U.S Born) ☐ Puerto Rican ☐ Cuban ☐ Other Hispanic (Non Mexican/Puerto Rican/Cuban)
☐ Declined to Specify

Preferred Language: **Do you need an interpreter?** ☐ Yes ☐ No

☐ English ☐ Korean ☐ Spanish ☐ Bengali ☐ Cantonese ☐ Mandarin ☐ Hindi ☐ Urdu ☐ Thai ☐ Tagalog ☐ Other:

Emergency Contact:	
Name:	Relationship:
Phone Number: Day	Phone Number: Evening
I authorize my emergency contact to pick up my medical records on my behalf: ☐ Yes ☐ No	

Advanced Directives **I am interested in receiving an Advance Directive Form.** ☐ Yes ☐ No

* Advance Directives is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity.

Preferred Pharmacy:	
Name:	Phone Number:
Address:	Zip Code:

* To be collected and updated annually for all patients for accurate FPL % *

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Consent for General Health

For patients ages 18 and over or patients under 18 living with parents/guardians or legally emancipated minors. For the purpose of obtaining diagnosis and/or treatment at the KHEIR Clinic, I hereby authorize any licensed practitioner associated with it to treat me or my minor child and to recommend and/or order laboratory tests or other specialized tests as indicated for diagnosis for me or my minor child's medical condition. I understand that medical records will be kept in a confidential manner; however, I acknowledge that information might be shared among health care providers associated with the Clinic in accordance with acceptable practice and pursuant to the law.

Adults

I am 18 years of age and older or legally emancipated minor.

Last Name	First Name	(M.I.)
DOB: _____(month)_____ (day) _____ (year)		
Signature: _____	Date: _____(month)_____(day) _____ (year)	

Minors

I am the parent/guardian of:

Child Last Name	Child First Name	(M.I.)
DOB: _____(month)_____ (day) _____ (year)		
Mother's Name	Father's Name	
Phone Number:	Phone Number:	
Signature: _____	Date: _____(month)_____(day) _____ (year)	

I authorize the treatment of my minor child if I am unable to be present. ☐ YES ☐ NO

If you selected "YES," complete the following form, titled "Caregiver's Authorization Affidavit"