**Smith Center for Infectious Diseases and Urban Health**
**310 Central Avenue, Suite 307 East Orange, NJ 07018**

**Date:** ________/________/_____________

**NAME:** ____________________________________________________________
First Middle Last

**Address:** __________________________________________________ **Apt #:**_____________

**City:** _______________________________________________ **ZIP CODE:** _______________

**Home Telephone #:** _______________________ **Cell Phone #:** _________________________

**BIRTH DATE:** ________/________/_____________ **Age:** ______________________________

**BIRTHPLACE:** ______________________ **SOCIAL SECURITY #:** _______-________-________

**GENDER:**

☐ Male ☐ Female ☐ Transgender

**RACE:**

☐ African-Am./Black ☐ Caucasian ☐ Hispanic ☐ Native American ☐Asian

☐ Multi-racial: ___________________________ ☐ Other: ___________________________

**IF HISPANIC, Region of Origin:** _________________________________________________

## Primary Care Physician

**Name:** ______________________________________________________________________

**Address:** ______________________________________________ **Suite #:**____________

**City:** ____________________________________________ **Zip Code:** ______________

**Phone #:** ______________________________________________

## Emergency Contact

**Name:** ______________________________________________________________________

**Phone #:** ______________________________ **Relationship:** _______________________

**Do you have any allergies?:** ☐ Yes ☐ No
**If yes, please specify:** _______________________________________________________

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**What medications are you currently taking?:**

1.______________________ 2.______________________

3.______________________ 4.______________________

5.______________________ 6.______________________

7.______________________ 8.______________________

9.______________________ 10.______________________

**MY HEALTH INSURANCE IS:**

☐ None ☐ Medicaid ☐ Medicare

☐ Private Insurance ☐ Veteran's Insurance ☐ Other: ______________________

**Are you medically able to work?:** ☐ Yes ☐ No

**ARE YOU HIV POSITIVE?:** ☐ Yes ☐ No

**If you are not HIV positive, why are you here today?:**

______________________________________________

______________________________________________

______________________________________________

**IF YOU DO NOT HAVE HIV/AIDS PROCEED TO LAST PAGE (Page 5)**

**IF YOU HAVE HIV/AIDS PLEASE FILL OUT THE ENTIRE FORM**

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**Where do you currently receive medical care?:**

☐ Private Physician ☐ Public Clinic/Department of Health ☐ VA Hospital

☐ Not currently in care ☐ Community Health Center ☐ Other: __________

**SEXUAL ORIENTATION:**

☐ I have sex with men only. ☐ I have sex with women only.

☐ I have sex with men and women.

**REFERRAL SOURCE:**

☐ Case Management Agency ☐ Prison/Jail ☐ Hospital Discharge

☐ Hotline ☐ Primary Care Physician ☐ Internet or Ad

☐ Current Smith Center Patient ☐ Friend ☐ HIV/Testing Site

☐ Other: ____________

**IF YOU ARE HIV POSITIVE, when where you diagnosed?:** _______/_______/__________

**HOW DID YOU GET HIV?:**

☐ I shared needles ☐ Sex with female ☐ Sex with male

☐ HIV positive sex partner ☐ I don't know ☐ Sexual abuse/assault

☐ Sex with injection drug user ☐ Blood transfusion ☐ Mother with HIV/AIDS

**EMPLOYMENT STATUS:**

☐ Full-time ☐ Part-time ☐ Self-Employed ☐ Unemployed ☐ Not in labor force

**LIVING IN:**

☐ Emergency Shelter ☐ Homeless ☐ HOPWA Long-term

☐ Hotel/Motel no voucher ☐ Ryan White Housing ☐ Hotel/Motel with voucher

☐ House/Apartment doubling up ☐ House/Apartment ☐ Nursing Home/Hospice

☐ Group Housing ☐ Residential Treatment Program

☐ Transition Housing Not Ryan White ☐ Transitional Housing Ryan White

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**I LIVE WITH:**

☐ Alone ☐ Partner/Spouse ☐ Children receiving child support ☐ Relatives

☐ Non-relatives ☐ Non-relatives sharing expenses ☐ Homeless ☐ Parent/Guardian

**DO YOU HAVE A FULL-TIME CARETAKER?:** ☐ Yes ☐ No

**HOW MANY DEPENDENTS DO YOU HAVE?:** ________________________ # of people

**MY INCOME SOURCES IS:**

☐ Employment ☐ Unemployment ☐ Disability ☐ Pension ☐ Public Assistance

☐ I don't have any income ☐ Other: ________________________________

**MY INCOME IS:** ______________________ **yearly** ______________________ **monthly**

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## PATIENT'S RIGHT TO PRIVACY ACKNOWLEDGEMENT OF RECEIPT

The Smith Center for Infectious Diseases and Urban Health Right to Privacy provides information about how we may use and disclose protected health information about you.

I acknowledge that I have received the Patients' Right to Privacy.

| ________________________________ | ________________________________ |
|---|---|
| Signature of Patient or Patient's Representative | Date |
| ________________________________ | ________________________________ |
| Print Name | Relationship to Patient |

If written acknowledgement is not obtained, please check reason:

______ Patients' Right to Privacy Given-Patient Unable to Sign

______ Patients' Right to Privacy Given-Patient Declined to Sign

______ Other_______________________________________________________

| ________________________________ | ________________________________ |
|---|---|
| Signature of Smith Center Employee | Date |

________________________________
Print Name