Oakland Integrated Healthcare Network
Patient Intake Form

Today's Date		Last Name		First	
Date of Birth		Social Security No.	- -		
Street Address		Apartment/Unit#			
City		State		ZIP Code	
Home Phone		Cell Phone			
Parent/Guardian		Relationship?			
Gender at Birth	☐Female ☐Male	Current Gender	☐ Female ☐ Male ☐ Other	☐ Transgender Male (Female to Male) ☐ Transgender Female (Male to Female) ☐ Choose not to disclose	
Sexual Orientation	☐ Straight/Heterosexual ☐ Lesbian or Gay ☐ Bisexual	☐ Something else ☐ Don't Know ☐ Choose not to disclose			
Race	☐ American Indian/Alaska Native ☐ Black/African American ☐ White/Caucasian	☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Refuse to Report			
Ethnicity	☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Refuse to Report	Language you are most comfortable with:	☐ English ☐ Spanish ☐ Other: ___________________		
Marital Status	☐ Single ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed				
Living Situation	☐ Own/rent a home ☐ Homeless ☐ Other: ________________				
Are you a veteran?	☐ Yes ☐ No	Agriculture Employment	☐ Migrant ☐ Seasonal ☐ Employed year round		
Emergency Contact	Name: ______________________ Relationship: ________________ Phone #:_____________________				
Primary Insurance	Insurance Company: ____ Policy Start Date:______________ Name of Policy Holder: _____________________________________ Policy ID #:___________________ Group/Plan #:____				
Secondary Insurance	Insurance Company: ____ Policy Start Date:______________ Name of Policy Holder: _____________________________________ Policy ID #:___________________ Group/Plan #:____				
☐ Patient has verbally consented to a telehealth visit					

*If possible have patient sign below

Patient Signature: ____ Date: _________________