Aid to Women CENTER

GENERAL INFORMATION

Date:

Name: _____ Age: ___ Date of Birth: _____ / _____ / _____

Address: _____ City: ____ State: _ Zip Code: _____

Phone Number: _____Your occupation: _

REFERRAL SOURCE (circle all that apply)

Family	Friend	Agency	Medical Facility	Brochure	Church	Radio
Television	Newspaper	Phone Book	High School	Hotline	Counselor	Other

MARITAL STATUS (circle all that apply)

Single Married Living Together Separated Divorced Widowed

Spouse's Name: _____ Spouse's Occupation: _____

ETHNIC GROUP (circle one)

African American Asian Caucasian Hispanic Native American Other:_____

Occupation:_____ Religious Preference:_____

SYMPTOMS (circle all appropriate symptoms – specify duration)

None	Discharge	Body rash	Pain with urination
Penile itch	Genital rash	Sores/Lesions	

List any known medical allergies: _____

RISK ASSESSMENT	Yes	No	Unk	**Medical HX**	Yes	No
1. Drug Use? Type: _____ 2. Sex with males? 3. Multiple sex partners? Number in the past year _____ 4. Partner IV drug user?				Other current or chronic health problems? If YES, list: _____ _____ Current or recent medication? If YES, list: _____ _____		

Medical/STD History – STD/HX Have you ever had an STD? List below.	Yes	No	Date
Syphilis			
Gonorrhea			
Chlamydia			
Herpes			
HPV			
Other			

Master Forms: Men's Mecical Form 10/10

1328 E. Apache Blvd
Tempe, AZ 85281

CONSENT FOR MEDICAL TREATMENT

I, _____ hereby agree to receive the following service(s) from
Name (PLEASE PRINT)

AWC Medical Clinic (check one):

- ❑ **Medical Services**
  - Includes STD/HIV screening for men, or basic evaluation by a doctor, nurse, or other qualified personnel.

I hereby give AWC Medical Clinic full consent to any and all procedures performed by AWC Medical Clinic medical staff. I waive and release any and all claims, whatsoever kind and nature, that I, my baby, or legal representative or heirs and realities might have or hereafter have against AWC Medical Clinic, its practitioner, medical personnel, directors, officers, employees, and volunteers.

I expresssly agree that this waiver, release, and indemnity agreement is intended to be as broad and inclusive as permitted by the laws of the state of Arizona, and that if any portion thereof is held invalid, it is agreed that the balance shall, not withstanding, continue in full legal force and effect.

To provide medical services AWC Medical Clinic must be able to contact you, either by telephone or by mail. Please provide the following information:

_____ _____
Name (PLEASE PRINT) Telephone Number

_____
Address City/State Zip Code

THIS FORM MUST BE SIGNED PRIOR TO RECEIVING ANY SERVICES:

_____ _____
Patient's Signature Date

_____ _____
AWC Witness Signature Date

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CENTER

Notice of Privacy Practices Acknowledgement

Notice of Privacy Practices (NPP) is provided to all patients. This **Notice of Privacy Practices** identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request accounting and disclosures of your medical information, and request additional restrictions on your uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintain the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the **Notice of Privacy Practices** and is the patient or the patient's personal representative.

_____ _____

Name of Patient Signature of Patient

Date Signed: _____

_____ _____

Name of Patient's Personal Representative Signature of Representative

Date Signed: _____

****

FOR INTERNAL USE ONLY

_____ _____

Name of Employee Signature of Employee

If applicable, reason patient's written acknowledgment could not be obtained

__ Patient was unable to sign

__ Patient refused to sign

__ Other _____

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