SACRAMENTO LIFE CENTER
Patient Intake – Male Patient Advocate Appointment

Official Use Only
Time Out ID Verification Done
Pt. Name: ☐ Pt. DOB: ☐
Your Initials: _____

Official Use Only
Patient is at risk for falls
YES ☐ Form completed
NO ☐
Your Initials: _____

Official Use Only
DVS
YES ☐
NO ☐ Your Initials: _____

❑ Sacramento Clinic ❑ Mobile Clinic

Date of Visit:	Type of Visit: ❑ New ❑ Return	What is the primary reason for this visit? ❑ Patient Advocate Meeting ❑ Other _____

First Name:	Last Name:	MI:

Mailing Address:	City:	State:	Zip:

Phone:	May we leave a message? ❑ Yes ❑ No
Is it OK for us to contact you? (Check all that apply) ❑ By Phone ❑ By Mail ❑ By Email/Text ❑ No	If ok to contact by email, please provide current email:

Date of Birth: Age:	Insurance Coverage: ❑ Medi-Cal ❑ Private: _____ ❑ None	Race: ❑ African American ❑ Asian ❑ Caucasian ❑ East Indian ❑ Haitian ❑ Hispanic ❑ Native American ❑ Pacific Islander ❑ Other

Income: ❑ Employed ❑ Unemployed ❑ Dependent Source: ❑ Self ❑ TANF/SSI ❑ Parents	I live with: ❑ Alone ❑ Homeless ❑ Spouse ❑ Boy / Girl friend ❑ Parent(s) ❑ Other _____ ❑ Children ❑ Roommate ❑ Fiancé ❑ Shelter
Occupation or Job Title: Place of Employment: School Attending:	Marital Status: ❑ Single ❑ Engaged ❑ Married ❑ Live Together ❑ Separated ❑ Divorced
Student Status: ❑ Middle School or Jr. High ❑ High School ❑ College or University ❑ Not Student ❑ Trade School/Other	Religious Denomination: _____ Would you like a referral to local organizations that can provide help with your spiritual needs? ❑ Yes ❑ No
Have you ever been to Sacramento Life Center before? ❑ Yes ❑ No ❑ Same Name Other name? _____	List any information about pregnancy, parenting or other services we can assist you with: _____

How did you hear about us?	Name of person you are accompanying?	Relationship?
_____	_____	_____

_____ ____/____/____
Patient Signature Date

_____ ____/____/____
Reviewed By Sacramento Life Center Staff-Signature Date