

Onboarding forms

Saving...

Name & Gender

First Name

Middle Name

Last Name

Suffix

Nickname

Sex

▼

Gender Identity

▼

Sexual Orientation

▼

Patient Background

Saving...

Date of Birth

mm/dd/yyyy

Social Security #

###-##-####

Preferred Language

Race

Ethnicity

Contact Information

Email Address

yourname@example.com

Home Phone

555-555-5555

Cell Phone

555-555-5555

Work Phone

555-555-5555

Saving...

Address

Street Address

Address line 1
Address line 2 (optional)

City

State

—Select a State—

Zip Code

Emergency Contact

Name

Relation

Phone

555-555-5555

Saving...

Additional Information

Preferred Pronouns

Who referred you?

- ☐ Do you use online scheduling?
- ☐ Want access to online portal?

Anything special we need to know

Changes to Medications

Medication & Dosage	Indication
No drugs recorded	

Changes to medications

Saving...

Changes to Allergies

Allergy	Reaction
No allergies recorded	

Changes to allergies

Changes to Medical Conditions

Problem	Code	Status	Diagnosed
No medical conditions recorded			

Changes to medical conditions

Primary Insurance

Primary Insurance Company

Saving...

Plan Name

Insurance ID Number

Group Number

Patient Student Status

☒ Are you the insurance subscriber?

Reasons For Visit

Hepatitis C (Prevention, Testing, and Treatment)

☐ Yes

☐ No

HIV (Prevention, Testing, and Treatment)

☐ Yes

☐ No

Are You On PrEP?

☐ Yes

☐ No

Saving...

Personal Medical History

Have You Ever Been Diagnosed With

Allergies

☐ Yes

☐ No

What Are You Allergic To?

Anxiety

☐ Yes

☐ No

Asthma

☐ Yes

☐ No

Cancer

☐ Yes

☐ No

Depression

☐ Yes

☐ No

Diabetes

☐ Yes

☐ No

Heart Disease

☐ Yes

☐ No

Hepatitis or Liver Dysfunction

☐ Yes

☐ No

High Blood Pressure

☐ Yes

☐ No

High Cholesterol

☐ Yes

☐ No

HIV/AIDS

Saving...

☐ Yes☐ No**Kidney Disease**☐ Yes☐ No**Mental Health Condition**☐ Yes☐ No**Neurological Conditions**☐ Yes☐ No**Sexually Transmitted Infections**

Chlamydia

Gonorrhea

Herpes

HPV

Pelvic Inflammatory Disease

Hold the Shift or Control key to select multiple options (Command key on Mac)

TB☐ Yes☐ No

Do You Take Any Medications or Supplements? If so, please list.

Social History

Do You Use

Alcohol
Cigarettes
Illicit Drugs
Smoke

Saving...

Hold the Shift or Control key to select multiple options (Command key on Mac)

How Many Sexual Partners Have You Had In The Last 30 Days?

How Many Sexual Partners Have You Had In Your Lifetime?

Do You Use Condoms?

☐ Yes

☐ No

Do You Engage In Anal Sex?

Give
Receive
No

Hold the Shift or Control key to select multiple options (Command key on Mac)

Do You Engage In Oral Sex?

☐ Yes

☐ No

Do You Engage In Vaginal Sex?

Give
Receive
No

Saving...

Hold the Shift or Control key to select multiple options (Command key on Mac)

Do You Consider Yourself A Sex Worker?

☐ Yes

☐ No

Is There A Chance You May Be Pregnant?

☐ Yes

☐ No

Questions & Comments

Question or Comment #1

Question or Comment #2

Question or Comment #3

Consent & Signature

4 unread consent forms

Saving...

<input type="checkbox"/>	Patient Assistance Fund ()	Required
<input type="checkbox"/>	Assignment of Benefits ()	Required
<input type="checkbox"/>	Consent Forms ()	Required
<input type="checkbox"/>	HIPAA Data Use Agreement ()	Required

I'm done