TEXAS Department of State Health Services
TX DSHS Public Health Nursing

CLEAR FORM

Client Information

Name: _____ _____ _____DOB:_____
(Last) (First) (MI)

Birth Asn Sex: ☐M ☐ F Gender: (check all that apply) ☐M ☐F ☐Transgender ☐Self Define:_____

Relationship status: (check one)

☐Single ☐In monogamous relationship ☐Married/Domestic Partnership ☐Divorced ☐Separated

Referred by(check one) ☐self ☐family ☐physician ☐school ☐hospital ☐DSHS ☐Other:_____

Pref. language _____Country of Birth _____ Ethnicity _____

Contact Information

Mailing/Street Address: _____

City: _____/_____County: _____/_____Zip_____/_____
(CODE) (CODE)

Preferred form of contact: ☐ Voicemail ☐ Text ☐ Email

Ph: Home/cell _____ Prefer: ☐Text ☐Voice Mail ☐Do not leave a message

Ph: Work _____ ☐Do not leave a message

Email Address: _____ ☐Do not email me

Type of Dwelling: _____ #of rooms _____ #Adults_____ #Children _____

Directions to House: _____

_____

Please check off if you have access to the following:

☐Electric ☐Refrigerator ☐Running Water (check one) ☐ well ☐ city

☐Sewage (check one) ☐leach ☐city ☐Heat (check one) ☐ central ☐space heater ☐Stove ☐ Hotplate(check one)

Household Roster

Social Security #	Household Members	Relationship to Client	Date of Birth
1.			
2.			
3.			
4.			
5,			
6.			
7.			
8.			
9.			
10.			

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Cl. Name: _____

SS# _____

ID# _____

DOB: _____

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Client Information

Summary of Clinic Services Utilized by Client	
Services	Agency

Types of Income (check)

- ☐ TANF
- ☐ ECI
- ☐ SNAP
- ☐ Austin/Travis county Integral Care
- ☐ SSI
- ☐ DARS
- ☐ SOCIAL SECURITY
- (OTHER) _____
- (OTHER) _____

Program Eligibility/Enrollment

VFC: ☐ Y ☐ N

WIC: ☐ Y ☐ N

WIC Number: _____

Title V: ☐ Y ☐ N

Last Updated: _____

Financial Profile

PRIMARY INSURANCE

Insured Name:_____

Employer/School:_____

Address:_____

City: _____State:_____Zip:_____

Date of Birth: _____

Notes:

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Cl. Name: _____

SS# _____

ID# _____

DOB: _____