SAFE CLINIC PATIENT SIGN-IN

Date _____

Legal Name_____
First Name Last Name

Gender_____ Preferred Pronouns_____

Current Address _____
Street number and name City TN Zip

Telephone Number _____

Date of Birth _____Age_____

Race / Ethnicity_____

Social Security Number _____

Date of Assault _____

City and state where assault occurred _____

You will not be billed for any services provided to you today at the Sexual Assault Center SAFE Clinic. All of the above information is needed so we may submit a bill to the state SAFE fund for reimbursement of your visit. Please complete all of the above requested information. Thank you.

Emergency Contact _____

Emergency Contact Phone Number _____

Consent for Treatment

Please sign below consenting for treatment at the Sexual Assault Center SAFE Clinic. All procedures and interventions will be explained by the medical staff and you may withdraw your consent for any or all treatment at any during your visit.

Patient Signature _____