Planned Parenthood of Greater Washington and North Idaho
123 E Indiana Ave., Spokane, WA 99207 1.866.904.7721

SOCIAL/FINANCIAL HISTORY

PPGWNI's confidentiality policy puts patient privacy first. This means what you tell us remains private and will not be shared unless we are legally required to do so by Washington State law. The agencies we are required to report to will also keep your information confidential within the law.

Under Washington State Law, WAC 246-101; We are required to report sexually transmitted infections to the Department of Health who will help provide confidential partner notification and treatment services for the following: Chlamydia, Gonorrhea, Syphilis, Herpes Simplex virus(Genital – initial infection only), Human immunodeficiency virus (HIV) / AIDS, and other rarer STDs.

Under Washington State Law, RCW 26.44.030(1)(a); We are also required to report to law enforcement or Child Protective Services (CPS), any situation that could mean possible abuse, neglect or sexual coercion/exploitation of any person under the age of 18 years old.

We encourage you to talk to us if you or someone you know needs help with staying safe. We are here to help you. **Staff Initials:** _______

Date: _____/_____/_____ SSN: ______________________ ❑ Male ❑ Female

Last Name: ______________________________ First Name: ______________________________ MI: ________

Title: (✔ One) ❑Mr. ❑Mrs. ❑Ms. ❑Dr. Suffix: (✔ One if applies) ❑Sr. ❑Jr. ❑II Date of Birth: ____/____/____ Age: _____

Other Names Used: ____

For medical reasons, we must have a way of contacting you. If you wish to not be contacted at home, please provide an alternate (such as work, friends or relatives) phone number and address or discuss other contact options with our staff. If we are unable to contact you, confidentiality may be broken in order to do so. This could be for potentially life threatening situations such as a severely abnormal Pap smear result. With your consent we can also contact you by email or text, but are required to inform you that such communications are not guaranteed to be secure.

❑ **I can receive mail at the following address:**
❑ Home Address ❑ Alternate Address

❑ **I cannot receive any mail.**
In this case we cannot bill any private insurance.

Street Address: ______________________________ Apt #: ___________

City, State, Zip: ____

I can be reached at this phone number: ______________________
This is my: ❑ Home # ❑ Work # ❑ Cell # ❑ Other #
Additional numbers: ______________________
PPGWNI may contact me via text ❑ Yes ❑ No
PPGWNI may contact me via email ❑ Yes ❑ No
Email Address: ______________________________

(Please check one box)
❑ It is OK to say Planned Parenthood.
❑ It is OK to say Dr's office.
❑ Use code name "Please call **Bonnie /Penny**" ***(circle one)***
❑ Do not leave a message.
❑ No phone contact.

What is your Ethnicity? (✔ One) ❑ Hispanic ❑ Non-Hispanic

Number of Pregnancies? ______________

Race: (✔ all that apply) ❑ White ❑ Black ❑ Asian ❑ American Indian ❑ Alaskan Native ❑ Hawaiian/Pacific Islander ❑ Other

Preferred Language: ❑ English Other: ____________________

Other information: ❑ Limited English Proficiency

Marital Status: (✔ One) ❑Single ❑Married ❑Divorced ❑ Legally Separated ❑Widowed

Referral Information: How did you hear about us? (✔ One)
❑ Friends ❑ Family Member ❑ Radio ❑ Google ❑ Newspaper ❑ Email Ad
❑ Yellow Pages ❑ Automated Call ❑ Bill Board ❑Facebook ❑ Referring Agency ❑ Text Message
❑ Website ❑ PPGWNI Education Program ❑ Referral from Other Medical Provider ❑ Promotoras

NAME:
DOB:
PPGWNI:

Alternate contact (No health information will be given):

Name: ______________________________ Phone: ___________________ Relationship to you: _______________________

Other Account Authorizations:

List of person(s) able to pick up supplies for you: ____

List of person(s) able to make payments for you: ____
(Receipt will be mailed to the address on file.)

Income and Insurance Assessment:

Monthly household income before deductions: $__________

How many people are supported by this income? __________

How many of these are children? __________

Do you receive Washington Provider One card or Oregon State Medical coupons? ❑ Yes ❑ No

Do you receive Take Charge Provider One card? ❑ Yes ❑ No

Do you have any other medical insurance coverage? *(If yes, please complete the section below.)* ❑ Yes ❑ No

(PPGWNI Staff Only) Assigned Funding Group: ____

Insurance Information ***(Please fill out if you carry Private Insurance.)***

Primary Insurance

Subscriber Information: Subscriber Name: _________________________ Subscriber Date of Birth: ________________

Subscriber SS #: ______________________ Patient relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Subscriber Employer: ____

Insurance Information:

Insurance Company Name: ____

Insurance Billing Address: ____

Benefits Phone Number: (____) _______________________

Insurance ID:______________________________ Group/Plan #: ____________________

Secondary Insurance

Subscriber Information: Subscriber Name: _________________________ Subscriber Date of Birth: ________________

Subscriber SS #: ______________________ Patient relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Subscriber Employer: ____

Insurance Information:

Insurance Company Name: ____

Insurance Billing Address: ____

Benefits Phone Number: (____) _______________________

Insurance ID:______________________________ Group/Plan #: ____________________

The use of Title X funds and services are provided to the patient on a strictly voluntary basis.

Please read the following and sign in the space provided below: I understand that full payment is due at the time I receive services (we accept cash, checks, or Visa/MasterCard). I am financially responsible for any balance due, for any and all services provided, including those not covered by my insurance: I understand that if I submit a Provider One Card or use Take Charge funding for payment of services, DSHS will be billed. In the event DSHS denies payment because I have other insurance, the bill will be submitted to my insurance company for payment. I authorize Planned Parenthood of Greater Washington and North Idaho or my insurance company to release any information required for this claim and direct my insurance benefits to be paid directly to Planned Parenthood. ***I understand that an insurance or Medicaid billing could result in information regarding my care at Planned Parenthood being sent to my parent, guardian, or spouse - whoever is the holder of the insurance policy or Medicaid card.*** *I understand that if I am leaving an unpaid balance on my account, I will receive a bill.*

Patient Signature: ____ **Date:** _____/_____/_____

NAME:

DOB:

PPGWNI:

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USE OF EMAIL, TEXT, RECORDED VOICE MESSAGES PERMISSION FORM

Risks of Using E-Mail, Text or Recorded Voice Messaging:

E-mail, text messaging, and voice messaging is not reliable, secure, or private. For example:

- E-mail can be hacked. (Unauthorized people can intercept it, alter it, or use it).
- E-mail, text messages and voice messages can be sent to the wrong person, lost, or subject to other sending errors.
- E-mail and text messages may come from someone other than the named sender.
- E-mail is easier to alter than handwritten, signed papers.
- Anyone with access to an e-mail account will have access to all messages in that account, and anyone with physical access to a cell phone could have access to emails,
- Text messages and voice messages if the device is not electronically secured.
- Anyone who gets or has access to an e-mail, text message, or voice message can read, forward, copy, delete, or change it.
- Any deleted e-mails, text messages, or voice messages can be recovered by the service provider.
- E-mail services have a right to save and check e-mail sent through their system.
- E-mail can contain viruses.

Scope of Permitted Use of Email, Text and Recorded Voice Messages:

I permit Planned Parenthood of Greater Washington and north Idaho to send me e-mails, texts or recorded voice messages.

I acknowledge and accept that the agreed upon e-mails, text messages or voice messages sent to and from Planned Parenthood of Greater Washington and North Idaho, may be read by everyone who gets or has access to them. They will know that the messages are from Planned Parenthood of Greater Washington and North Idaho, and they will be able to view their content.

I agree to release and hold harmless Planned Parenthood of Greater Washington and North Idaho from any liability that may result from using the methods of communication I have given consent to in this permission form. This includes, but is not limited to, breaches of confidentiality or privacy that may come from using those methods of communication (except as required by law).

_______________________________ _________________

Patient Signature Date

___________________________________ _________________

Parent / legal guardian / authorized person signature Date

NAME:

DOB:

PPGWNI #:

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REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Planned Parenthood may need to refer me to another health care facility to provide the services necessary for my care.

I understand that the information I will provide is true, accurate, and complete and that my healthcare choices will depend on that information.

I will be given information about the test(s), treatment(s), procedure(s), and contraceptive method(s) to be provided, including the benefits, risks, possible problems/complications, and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Planned Parenthood.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I will be told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in Planned Parenthood of Greater Washington and North Idaho's *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.

Please note that Planned Parenthood of Greater Washington and North Idaho is a teaching institution, and that persons in training, under strict supervision, may be involved in some aspects of your care.

NAME:

DOB:

PPGWNI #:

I hereby request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, if I request it).

I hereby acknowledge receipt of Planned Parenthood of Greater Washington and North Idaho's notice of health information privacy practices.

Signature of patient ___________________________________ Date ___________________

I witness the fact that the patient received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.

Signature of witness ___________________________________ Date ___________________

	CHECK HERE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW

Signature of any other person consenting ____

Relationship to patient _________________________________ Date ________________

I witness the fact that the patient's legal guardian (or person consenting in her behalf) received the above mentioned information and said she read and understood same.

Signature of witness ____________________________________ Date ________________

NAME:

DOB:

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Planned Parenthood®
Care. No matter what.

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MEDICAL HISTORY

Client Information: Date: ____________

Client Name: ________________________________ Client ID: ____________ Sex: __________

Date of Birth: ____________________ Age: _______ Clinic Location: ___________________________

Reason for Visit____

Are you taking any **medications**, vitamins, or supplements? If yes, which ones?

____

Are you **ALLERGIC** to any medications, latex, copper, or iodine? If yes, what?

____

Check if Yes

☐ Any new or long-term medical conditions?
☐ smoke cigarettes ☐ chew tobacco
☐ Any concerns about alcohol over use?

CURRENT SIGN OR SYMPTOMS OF INFECTION

Check if Yes

☐ ABNORMAL genital/rectal bleeding? ☐ ABNORMAL genital discharge?
☐ Itching or burning in the genital area? ☐ Bumps, sores or pain on genitals?
☐ Pain or bleeding during/after sex? ☐ Severe pelvic or abdominal pain?
☐ Temperature above 100.4? ☐ Urinary pain, frequency or bloody urine?
☐ These are partner symptoms

Have you or your partner had:
☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HIV ☐ Genital warts ☐ Syphilis ☐ PID

When were you treated: ____

GENERAL RELATIONSHIP HISTORY

Check if Yes

☐ Have you **ever** been physically, emotionally, or sexually abused by your partner or someone important to you?
☐ Has your partner **ever** messed with your birth control or tried to get you pregnant when you didn't want to be?
☐ Do you have concerns about relationship communication or dating violence?

Are your partners: ☐ Male ☐ Female
Sites of sexual contact: ☐ Vaginal ☐Oral ☐ Anal
Number of partners in last 12 months: _________
Number of Partners in last 2 months: __________

☐ Are there times when you do NOT use a condom during sex?
☐ Have you had sex in exchange for drugs or money?
☐ Have you or your partner injected street drugs (shot-up)?
☐ Have you ever had a blood transfusion?
☐ Have you ever been exposed to or treated with blood products?
☐ Would you like information about: ☐ HIV testing ☐ HPV Vaccine ☐ Menopause ☐ Other

CONTRACEPTION HISTORY

When was the first day of your last normal menstrual period? _____________

Check if Yes

☐ Are you having problems with your periods (irregular, heavy, severe pain)? _________
☐ Are you currently on a Birth Control Method? If yes what type: ________________
☐ Would you like a different birth control method today? If yes what type: ___________
☐ Do you have symptoms of pregnancy? If yes please check
☐ missed period ☐ sore breasts ☐ nausea ☐ fatigue ☐ urinary frequency
☐ Have you had problems with birth control? _______________________________
When was your last sex **without** a condom or birth control method since your last menstrual period? _____________
☐ Are you breastfeeding?

REVIEW of SYSTEMS

Check If Yes

☐ Vaccinated for : ☐ Hepatitis B ☐ Hepatitis A ☐ MMR ☐ HPV ☐ Flu
☐ Do you have a condition that causes your bones to be brittle and break easily, or osteoporosis?
☐ Bleeding, blood disorder? Current anemia? Diagnosis of Lupus?
☐ Blood clots in the legs or lungs? (not varicose veins)
☐ Cancer (including breast and/or ovarian)? *(Staff to complete MR 02.043.00 Breast Risk Screening Questionnaire A)*
☐ *High Blood Pressure*
☐ High blood pressure during pregnancy
☐ High Cholesterol
☐ Heart Valve Problems
☐ Heart Palpitations
☐ Heart Disease / Heart Attack
☐ Severe depression?
☐ Diabetes?
☐ Diabetes during pregnancy?
☐ Thyroid disorder?
☐ Are you planning surgery or previous surgeries (including breast, reproductive, and weight loss)?
☐ Active gall bladder disease?
☐ Liver disorder or tumors or Hepatitis?
☐ Neurological conditions (including stroke, epilepsy, or menigioma)?
☐ Stomach or bowel problems? (not occasional constipation)
☐ Bladder or kidney disease?
☐ Reproductive or Hormone problems?
☐ Migraine headaches?
- ☐ Sensation of Numbness?
- ☐ Vision changes that start before the headache
- ☐ Vision changes that last up to one hour before the headache
- ☐ Vision changes that go away before the headache actually starts

☐ Do you have a history of abnormal PAP tests (positive HPV or pre-cancer changes)? If yes what:

____

☐ Have you had a mammogram or breast ultrasound (x-ray)? If yes Date/Results________________________________

☐ History of abnormal breast findings, including lobular carcinoma insitu (LCIS) or atypical hyperplasia of the breast-biopsy proven?

☐ Prior thoracic irradiation treatment?

GYNECOLOGICAL HISTORY

Check if Yes

☐ Have you ever been pregnant?

Live Births_______ Miscarriage _______ Tubal _______ Molar _______ Termination_______

Vaginal Delivery: ______ C-Section Delivery: ________

Age you had your first period: _______ Age at first sexual intercourse? _______ Age of menopause: ________

When was your last pap? ___________________________ Results: ____________________________________

BIRTH PARENTS/FAMILY MEDICAL HISTORY

☐ Adopted or no family history available.

Check if Yes

☐ Has your **FATHER** or **BROTHER** before the age of **55** had a heart attack? **OR** your **MOTHER** or **SISTER** before age **65**?
☐ Has your **MOTHER, FATHER, BROTHER, OR SISTER** ever had a blood clot (in the lungs or legs) or bleeding/blood clotting disorder?

☐ Has a blood relative had breast or ovarian cancer? *(Staff to complete MR 02.043.00 Breast Risk Screening Questionnaire B)*
☐ High blood pressure
☐ If you were born before 1972, did your mother use a drug called DES for the prevention of miscarriage during her pregnancy with you?