

**PLANNED PARENTHOOD OF HAWAII  
Patient Registration Form**

First Name	MI	Last Name	Marital Status	Circle One: Divorced Liv Together Married	Single Widowed Separated	
Street Address(Line 1)			How were you referred to this clinic?			
Street Address (Line 2)			Are you a student? Circle One: Yes No			
City	State	ZipCode:	If you are a student, what type of student? Circle One: Junior High High School College Graduate School			
County			What is the highest grade of school you completed?			
Social SecurityNumber			Citizen Status Circle One: U.S. Citizen Immigrant *Compact States * Palau, Micronesia or Marshal Islands			Refugee Student Visa Tourist Visa Other
Date of Birth		Age	How will you be paying for this visit? (Circle one)			Health Insurance Self-Pay
Family Income \$	Circle One: Yearly Monthly Bi-Weekly Weekly		Do you have Health Insurance? Circle one: Yes / No			Primary Insurance: _____ Subscriber #: _____ Other Insurance: _____ Subscriber #: _____
Number of people in family who depend on this income		Number of children	Please remember that insurance may not cover all fees for your services. It is your responsibility to pay any deductible, co-insurance, or any other balance not paid by your insurance.			
Home Telephone or Cell Phone (Circle which phone)			I authorize Planned Parenthood of Hawaii to release my medical records to any organization or agency which is or may be liable for any portion of the charges for my service.			
Work Telephone			<b>I certify that the information I give about my income and household size and insurance is true and accurate to the best of my knowledge.</b>			
Emergency Telephone # / Contact Name / Relationship			Signature: _____			
Who can we say is calling? Circle One:		PPH Dana Other Code name:				
How can we send you mail? Circle One:		Plain Envelope Regular Mail - PPHI ID OK				
Email Address			Date of Signature: _____			
Can you receive EMail? Circle One: Yes No						
Sex Circle One: Male Female						
Ethnicity - Circle All That Apply: African American Korean Samoan American Ind/AK Native Laotian Vietnamese Caucasion/White Marshallese Other Asian Chinese Micronesian Other Pacific Islander Filipino Portuguese Guamanian Hawaiian/Part Hawaiian Puerto Rican/Mexican/Cuban Japanese			<b>For Office Use Only</b>			
Hispanic Origin Circle One: Hispanic Non-Hispanic		Patient Number	Funding Source			
		Assigned Site	Pay Source			
		Field 1	Field 4			
		Field 2	Field 5			
		Field 3	Field 6			

**Thank You! Please give this completed form and health insurance cards to Receptionist.**