



Planned Parenthood Hudson Peconic, Inc.
Serving Suffolk, Westchester, Rockland and Putnam Counties

REGISTRATION FORM

Date _____

New Patient: Welcome and please complete the form.

Were you a patient at a Westchester County Family Planning Clinic in the last 2 years? Yes No

Returning Patient: Welcome back, please fill in type of visit, your name and date of birth. If there are any changes in the information below please complete the form.

Type of visit: Please indicate the type of visit you are planning on having today.

- Annual exam Medical problem visit Emergency Contraception Pregnancy Test
 Surgical Abortion Medication Abortion Prenatal Colposcopy
 Supply Visit Only (for returning patients only) Other _____

Do you need an interpreter to communicate with us? Yes No If yes, what language? _____

Name: _____ Sex: Female Male

Date of Birth: _____ Social Security #: _____ - _____ - _____

Address: _____
Street Apt. #

City State Zip

Phone () _____ () _____ () _____ () _____
Home Work Cell Emergency Phone

We must be able to contact you by phone Cell Phone Only Don't Leave a Message Say Dr. Calling OK to say PP

We must be able to contact you by mail PP Envelope Plain Envelope Star Letter/Plain Envelope

Do you have e-mail? Yes No If yes, e-mail address _____

Do you have Insurance? Yes No

If yes, what? Medicare/Medicaid FPEP FPBP Medicaid Managed Care Private Insurance

If Medicaid managed care or private insurance, name of insurance plan: _____

1. Weekly income _____ Number of people salary supports _____
2. Race: White Black American Indian Alaskan Native Asian/Pacific Islander Other
3. Hispanic Origin/Descent? Yes No
4. Are you currently employed? Full-time Part-time Unemployed
5. Student Status? Full-time Part-time Highest grade of school completed _____
6. Type of Birth Control you are currently using? _____
 If none, why? Infertility Not Sexually Active Not needed Other Medical Reasons
 Pregnancy Relying on Partner's Method Seeking pregnancy
7. Have you ever been pregnant? Yes No # of pregnancies before visit _____ # of Births _____
 # of stillbirths _____ # of miscarriages _____ # of abortions _____
8. Were you pregnant in the last 2 years? Yes No
9. Did you have Medicaid when your last pregnancy ended? Yes No
10. In addition to Planned Parenthood do you also get healthcare services elsewhere? Yes No
 If Yes, where? _____

Patient's signature: _____

OFFICE USE ONLY

Proof of Income: Payroll Stub Letter of Attestation Copy of Check Other _____

Date: _____ Staff signature _____



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HOJA DE REGISTRO

Fecha _____

Si visita este Centro por primera vez. Bienvenido. Por favor complete la siguiente forma.

¿Era usted un paciente en la clínica de planificación familiar del condado de Westchester en los últimos 2 años?

Sí No

Si ha estado antes en este Centro. Bienvenido nuevamente. Por favor, complete la siguiente forma incluyendo cualquier información distinta de la que usted proveyó en su visita anterior.

Tipo de visita: Por favor, indíquenos qué servicio requiere usted hoy.

- Examen anual Problema médico Anticonceptivo de emergencia Prueba de embarazo
 Aborto quirúrgico Aborto médico Cuidado prenatal Colposcopia
 Visita para buscar provisiones (sólo para pacientes que han visitado el Centro anteriormente)
 Otro servicio o propósito _____

¿Necesita usted un traductor/a para comunicarse con nosotros? Sí No Si es así, ¿Qué idioma habla? _____

Nombre: _____ Género: Mujer Hombre

Fecha de nacimiento: _____ Número de Seguro Social: _____ - _____ - _____

Dirección: _____
Calle Apt. #

Teléfono (____) _____ (____) _____ (____) _____ (____) _____
Ciudad Estado Código Postal
Casa Trabajo Teléfono celular Teléfono de Emergencia

De necesitar comunicarnos con usted, por favor, indíquenos la mejor manera de hacerlo:

Por teléfono: Celular No dejar mensaje Decir que el doctor llamó Decir que Planned Parenthood llamó

Por correo: Con un sobre en blanco Con sobre de Planned Parenthood Con una estrella/y un sobre en blanco

¿Tiene e-mail? Sí No Dirección de e-mail _____

¿Qué seguro médico tiene?

Medicaid FPEP FBPB Medicaid Managed Care Seguro privado No tengo seguro

Si es Medicaid Managed Care o un seguro privado, por favor provea el nombre: _____

1. Ingreso _____ Semanal Número de personas que dependen de este ingreso _____
2. Raza: Blanco Negro Indio Americano Nativo de Alaska Asiático Otro
3. ¿Es usted Hispano/Latino? Sí No
4. ¿Trabaja actualmente? Tiempo Completo Medio tiempo Desempleado
5. ¿Está en la escuela ahora? Tiempo completo Medio tiempo
 Grado más alto de escuela que ha completado _____
6. ¿Tipo de control de natalidad que está usando actualmente? _____
 Si ninguno, ¿por qué? Infertilidad No tiene relaciones sexuales Otra razón médica
 Embarazada Confía en el método utilizado por su pareja
 Busca salir embarazada
7. ¿Ha estado embarazada? Sí No Número de embarazos antes de esta visita _____ Número de partos _____
 Número de nacidos muertos _____ Número de abortos naturales _____ Número de abortos _____
8. ¿Estuvo embarazada durante los últimos dos años? Sí No
9. ¿Tenía Medicaid al momento de terminar su último embarazo? Sí No
10. ¿Además de Planned Parenthood, utiliza usted otro centro de cuidado de salud? Sí No
 ¿Cuál? _____

Firma del paciente: _____

OFFICE USE ONLY

Proof of Income: Payroll Stub Letter of Attestation Copy of Check Other _____

Date: _____ Staff signature _____



Planned Parenthood Hudson Peconic, Inc.
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**REQUEST FOR THE PROVISION OF MEDICAL SERVICES AND
 ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY
 PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

DATE: _____

SOCIAL SECURITY #: _____

TELEPHONE #: _____

Patient Name _____	
Patient # _____	DOB _____

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 have been given information about the test(s), treatment(s), procedure(s) 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 have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as much as possible, subject to Planned Parenthood Hudson Peconic, Inc.'s *Notice of Health Information Privacy Practices*. I hereby acknowledge receipt of Planned Parenthood Hudson Peconic, Inc.'s *Notice of Health Information Privacy Practices*, and I have had the right to review the *Notice* prior to signing this Request for the Provision of Medical Services.

I consent to the use and disclosure of my health information as described in Planned Parenthood Hudson Peconic, Inc.'s *Notice of Health Information Privacy Practices*. Except for the reasons described in the *Notice*, I may revoke this consent in writing at any time using the procedure in the *Notice*. I agree that this consent supercedes any and all previous consents, authorizations, releases, and other written legal permissions signed by me regarding use and disclosure of health information covered by this consent, and I release Planned Parenthood Hudson Peconic, Inc. and its health care providers from all liabilities related to their compliance with this consent.

Patient Name_____
Patient #_____ DOB_____

This is to certify that I have read this Request for the Provision of Medical Services, understand its content, and accept its terms. 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).

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 _____

PLANNED PARENTHOOD HUDSON PECONIC, INC.

PATIENT HISTORY (females only)
ALL INFORMATION IS CONFIDENTIAL

Patient Name _____
Patient # _____ DOB _____

Date _____

Address _____ Town _____ Zip _____ Phone # _____

Who can we contact in an emergency? _____
(Name) (Relationship) (Phone)

How can we contact you? Mail: Planned Parenthood envelope Plain envelope Phone Star

Date: _____																																																																																																																																																																															
<p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Receiving medical care with another health provider? Reason for visit(s): _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergic to any medications, foods, product or anesthesia? List: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Currently taking medications (including herbal remedies and vitamins) List: _____</p> <p align="center"><u>FAMILY HISTORY</u></p> <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you adopted?</p> <p><input type="checkbox"/> <input type="checkbox"/> Did your mother take DES while she was pregnant with you? (if you were born before 1971)</p> <p>Does your Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM), Grandfather (GF) have any of the following? Who</p> <p><input type="checkbox"/> <input type="checkbox"/> Increased Cholesterol _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Increased Blood Pressure _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart attack before 50 _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Osteoporosis _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Other _____</p> <p align="center"><u>MENSTRUAL HISTORY</u></p> <p>Age when period started: _____</p> <p>Periods are: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Painful</p> <p>Flow is: <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy</p> <p>Number pads/tampons daily _____</p> <p>Periods come every _____ days. Bleeding last _____ days.</p> <p>When was the 1st day of your last period? _____</p> <p>Was it normal? _____</p> <p>Problem with periods: _____</p> <p>STI History</p> <p>Have you had the following: <input type="checkbox"/> No <input type="checkbox"/> Yes Please check below.</p> <p><input type="checkbox"/> HPV/Warts <input type="checkbox"/> Herpes <input type="checkbox"/> Syphilis</p> <p><input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Abnormal Pap</p> <p><input type="checkbox"/> Trichomonas <input type="checkbox"/> PID <input type="checkbox"/> Molluscum</p> <p><input type="checkbox"/> Abnormal Pap</p> <p>Date treated: _____</p> <p><input type="checkbox"/> Recurrent vaginal infections</p>	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Yes</th> <th style="text-align: left;">No</th> <th style="width: 50px;"></th> </tr> </thead> <tbody> <tr><td>1. <input type="checkbox"/> <input 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21. <input type="checkbox"/> <input type="checkbox"/>	Asthma	_____																																																																																																																																																																													
22. <input type="checkbox"/> <input type="checkbox"/>	TB, lung disease	_____																																																																																																																																																																													
23. <input type="checkbox"/> <input type="checkbox"/>	Pelvic infection/pain/PID	_____																																																																																																																																																																													
24. <input type="checkbox"/> <input type="checkbox"/>	Cervical LEEP/Laser/Cone/Cryo	_____																																																																																																																																																																													
25. <input type="checkbox"/> <input type="checkbox"/>	Anemia (low iron)	_____																																																																																																																																																																													
26. <input type="checkbox"/> <input type="checkbox"/>	Sickle cell anemia/trait	_____																																																																																																																																																																													
27. <input type="checkbox"/> <input type="checkbox"/>	Blood transfusion	_____																																																																																																																																																																													
28. <input type="checkbox"/> <input type="checkbox"/>	Chronic skin condition	_____																																																																																																																																																																													
29. <input type="checkbox"/> <input type="checkbox"/>	Arthritis, joint pain	_____																																																																																																																																																																													
30. <input type="checkbox"/> <input type="checkbox"/>	Broken bones/fractures	_____																																																																																																																																																																													
31. <input type="checkbox"/> <input type="checkbox"/>	Osteoporosis	_____																																																																																																																																																																													
32. <input type="checkbox"/> <input type="checkbox"/>	Depression	_____																																																																																																																																																																													
33. <input type="checkbox"/> <input type="checkbox"/>	Psychiatric disorders	_____																																																																																																																																																																													
34. <input type="checkbox"/> <input type="checkbox"/>	Past surgery (s)	_____																																																																																																																																																																													
35. <input type="checkbox"/> <input type="checkbox"/>	Past hospitalization (s)	_____																																																																																																																																																																													
<u>REVIEW OF SYSTEMS</u>																																																																																																																																																																															
36. <input type="checkbox"/> <input type="checkbox"/>	Generally healthy	_____																																																																																																																																																																													
37. <input type="checkbox"/> <input type="checkbox"/>	Skin problems, rash/itching	_____																																																																																																																																																																													
38. <input type="checkbox"/> <input type="checkbox"/>	Recent weight gain or loss	_____																																																																																																																																																																													
39. <input type="checkbox"/> <input type="checkbox"/>	Eye problems	_____																																																																																																																																																																													
40. <input type="checkbox"/> <input type="checkbox"/>	Hearing problems	_____																																																																																																																																																																													
41. <input type="checkbox"/> <input type="checkbox"/>	Frequent nosebleeds, sinus problems	_____																																																																																																																																																																													
42. <input type="checkbox"/> <input type="checkbox"/>	Teeth/gum problems	_____																																																																																																																																																																													
43. <input type="checkbox"/> <input type="checkbox"/>	Frequent sore throat	_____																																																																																																																																																																													
44. <input type="checkbox"/> <input type="checkbox"/>	Thyroid problems	_____																																																																																																																																																																													
45. <input type="checkbox"/> <input type="checkbox"/>	Breast changes/lump/surgery	_____																																																																																																																																																																													
46. <input type="checkbox"/> <input type="checkbox"/>	Frequent cold, flu, etc.	_____																																																																																																																																																																													
47. <input type="checkbox"/> <input type="checkbox"/>	Chronic fatigue (>6 months)	_____																																																																																																																																																																													
48. <input type="checkbox"/> <input type="checkbox"/>	Numbness/sensory loss	_____																																																																																																																																																																													
49. <input type="checkbox"/> <input type="checkbox"/>	Stomach/bowel problems	_____																																																																																																																																																																													
50. <input type="checkbox"/> <input type="checkbox"/>	Breathing Problems	_____																																																																																																																																																																													
51. <input type="checkbox"/> <input type="checkbox"/>	Urinary symptoms	_____																																																																																																																																																																													
52. <input type="checkbox"/> <input type="checkbox"/>	Abnormal uterus	_____																																																																																																																																																																													
53. <input type="checkbox"/> <input type="checkbox"/>	Pelvic Pain	_____																																																																																																																																																																													
54. <input type="checkbox"/> <input type="checkbox"/>	Blood clotting disorder	_____																																																																																																																																																																													
55. <input type="checkbox"/> <input type="checkbox"/>	Anxiety	_____																																																																																																																																																																													
56. <input type="checkbox"/> <input type="checkbox"/>	Severe Mood Swings	_____																																																																																																																																																																													

