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:______________________________

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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 ultimos 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 ☐ Colposcopía
☐ 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. #

____
Ciudad Estado Código Postal

Teléfono (____)__________ (____)__________ (___)__________ (____)__________ .
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:_________________________

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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 ____

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PREGNANCY TEST, HISTORY AND COUNSELING

(All information will be kept strictly confidential)

Date________________ Age___________________

Phone____

Patient Name______________________________

Patient #___________________ DOB________

Address____
(street) (city) (state) (zip)

Who do we contact in an emergency?____
(name) (relationship) (phone)

MEDICAL HISTORY (please complete)

Do you have an allergy to any medications? ☐ Yes ☐ No__________________________________
Are you allergic to shellfish? ☐ Yes ☐ No
Do you have a medical problem presently? ☐ Yes ☐ No
In the past did you have any medical problems? ☐ Yes ☐ No
If yes, please list the problems you have____
Have you ever had surgery? ☐ Yes ☐ No
If yes, please list the surgeries you have had____

MENSTRUAL HISTORY:

What day did your last period start? _____________
Was this a normal period? ☐ Yes ☐ No
Is your period usually regular? ☐ Yes ☐ No

PREGNANCY HISTORY:

Have you ever been pregnant? ☐ Yes ☐ No
How many births?_______________________
How many abortions?_____________________
How many tubal pregnancies?______________
How many Cesarean sections?_____________
How many miscarriages__________________

Since your last period have you had?

Nausea ☐ Yes ☐ No
Breast Tenderness ☐ Yes ☐ No
Severe pelvic pain ☐ Yes ☐ No
Unusual bleeding ☐ Yes ☐ No

CONTRACEPTIVE HISTORY:

CHECK ALL THAT APPLY

Now	Past		Now	Past	
☐	☐	Pill____________ Brand	☐	☐	IUD_________ Brand
☐	☐	Depo Provera (shot)	☐	☐	Sterilization
☐	☐	Today's Sponge	☐	☐	Vasectomy
☐	☐	Condom	☐	☐	Rhythm/Natural
☐	☐	Withdrawal	☐	☐	Barrier Caps
☐	☐	Abstinence	☐	☐	Female condom
☐	☐	Diaphragm	☐	☐	Norplant
☐	☐	Foam/Sponge/Film	☐	☐	Evra Patch
			☐	☐	NuvaRing

Comments or problems with method(s)_____________
____
____
____

DO YOU DESIRE:

Yes	No		Yes	No	
☐	☐	Pregnancy test only	☐	☐	Birth control today
☐	☐	Pregnancy test and counseling	☐	☐	Schedule a pelvic exam / pap

Patient's signature____ Date______________

STAFF ONLY: Urine / blood Pos / Neg / inconclusive Run by:_____________________

☐ Pregnancy Test Fact Sheet provided

Negative results

☐ Discussed meaning of results
☐ Discussed birth control methods. Patient plans on continuing / starting____________________
☐ Appointment made for BCM / gyn exam
☐ Offered hormones without pelvic—to start OCs or hormonal injections with next menses after self-history form completed and reviewed by clinician
☐ Patient told to return to center for repeat pregnancy test if no menses in two weeks
☐ STI/HIV risk assessment done, safe sex stressed and risk reduction discussed
☐ Offer HIV test and recommended patient testing
☐ Other____

Staff signature:____ Date______________

Patient Name______________________________
Patient #____________________ **DOB**________

Positive results

☐ desires now ☐ desires later ☐ desired sooner ☐ not desired

Options x 3 discussed.

☐ patient is considering	☐ continuing	☐ termination	☐ adoption	☐ undecided
☐ patient is firm	☐ continuing	☐ termination	☐ adoption	☐ undecided

☐ Pregnancy confirmation form completed.
☐ Application for WIC given.
☐ If under 18 years of age, encourage parental / guardian involvement.

Continuing with the pregnancy:

- ☐ Discussed and encouraged to make first prenatal appointment now. PPHP's prenatal centers' telephone numbers and prenatal referrals given.
- ☐ Discussed prenatal concerns. Need for multivitamins with folic acid until given prenatal vitamins. No smoking, drugs or alcohol.
- ☐ Discussed safe sex and risk reduction. HIV/STI risk assessment done.
- ☐ Discussed health insurance
  - ☐ Has health insurance______________________________
  - ☐ PCAP discussed. Encouraged appointment and telephone number of PPHP center given
  - ☐ Discussed support system and plan
    Support person(s)______________________________
    Plan______________________________
- ☐ Prenatal packet / fact sheets given

Termination:

- ☐ Medication termination—weeks pregnant__________ (less than 56 days from first day of menses to day of medical abortion appointment). Procedure reviewed: Day 1—counseling, sonogram, lab work, pelvic exam, taking Mifeprex, given 800 mcg of misoprostol to take buccally on day two or three (24-48 hours after the mifepristone. Return to center one week later for repeat sonogram. Fact sheet given.
- ☐ Surgical termination—weeks pregnant___________ (less than 15 weeks and 6 days for an abortion at PPHP).
  - ☐ 1st trimester surgical abortion procedure discussed—sonogram, lab, counseling, procedure, recovery room, 2 week post AB check. Fact sheet given.
  - ☐ 2nd trimester surgical abortion procedure referral given. Fact sheet given.
  - ☐ IV sedation discussed. Fact sheet given.
  - ☐ Birth control method(s) discussed.
- ☐ After the termination the patient plans to use______________________________
- ☐ Finances discussed
  - ☐ Health insurance______________________________
  - ☐ Self
  - ☐ PCAP eligible and patient given the phone number of the center to make an appointment
- ☐ Safe sex stressed and risk reduction discussed. STI/HIV risk assessment done.
- ☐ Offered HIV test and recommended partner testing

Undecided

- ☐ Discussed prenatal concerns—no smoking, nutritious diet
- ☐ Prenatal packet and fact sheets on termination(s) given to patient for reference
- ☐ Discussed support system
  Support person(s)______________________________

- ☐ Safe sex stressed and risk reduction discussed. STI/HIV risk assessment done.
- ☐ HIV test offered and partner testing recommended.

Staff signature:______________________________ Date__________________