



New Client: Welcome and please complete the form.

Date _____

Returning Client: 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.

Name: _____

Address: _____
Street Apt. #

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

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

() _____
Emergency Phone Emergency Contact

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

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

Marital Status Single Married Legally Separated Other

Social Security #: _____ - _____ - _____ Date of Birth: _____ Sex: Female Male

How did you hear about PPHP? Dept. Social Svcs Friend Family Facebook or MySpace Internet
 Medical Provider Mobile Phone Text Message Phone Book Radio Ad School Referral
 Smart Wheels Van Train or Bus Station TV Ad Other

Reason for your visit today: _____

City/State or Country of Birth: _____

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. What is your primary language? Arabic Chinese English French Creole Portuguese Spanish
5. Do you need an interpreter to communicate with us? Yes No If yes, what language? _____
6. Are you currently employed? Full-time Part-time Unemployed
7. Student Status? Full-time Part-time Highest grade of school completed _____
8. 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
9. Have you ever been pregnant? Yes No # of pregnancies before visit _____ # of Births _____
of stillbirths _____ # of miscarriages _____ # of abortions _____
10. Were you pregnant in the last 2 years? Yes No
11. Did you have Medicaid when your last pregnancy ended? No Yes, estimated date last preg ended _____
12. In addition to Planned Parenthood do you also get healthcare services elsewhere? Yes No
If Yes, where? _____

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: _____
Policy holder name: _____

Client's signature: _____

Please be advised that, with the exception of co-pays and any other charges that you are responsible for under the terms of your insurance plan, all client payments will be applied first to any past-due balances.

OFFICE USE ONLY

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

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

Date: _____ Staff signature _____

This page has been left blank intentionally.