Planned Parenthood®
of Maryland, Inc.

CLIENT INFORMATION SHEET

Last Name	First Name	MI

Address

City	State	Zip

Preferred Phone #	Type of phone (Circle one) Home Work Cell Pager Other______	Alternate Phone #	Type of phone (Circle one) Home Work Cell Pager Other______

How should we identify ourselves when calling (Circle one)

Planned Parenthood "Your Dr's Office" Other: ________

Type of envelopes we should use for mailings (Circle one)

Planned Parenthood Logo Plain Envelope

Social Security Number	Date of Birth	Gender (Circle one) Male Female

Primary Care Physician (PCP)	PCP Telephone #

Emergency Contact Name	Relationship to You	Emergency Contact Phone #	Type of phone (Circle one) Home Work Cell Pager Other

What is Your Race? (Check one or more)

	American Indian		Asian		Black/African American
	Alaskan Native		White		Native Hawaiian or Pacific Islander

Hispanic Origin? (Circle one)

Yes No

Primary Language	Secondary Language	Marital Status Single Married Divorced

PRIMARY INSURANCE

Insurance Name	Policy Holder (Circle one) Self Dad Mom Spouse Other: _______________
Policy Holder's Name (If other than self)	Policy Holder's Address (If other than self)

Policy Holder's Date of Birth	Policy Holder's Social Security Number	Policy Holder's Employer

SECONDARY INSURANCE (Fill in only if you have another insurance)

Secondary Insurance Name	Policy Holder (Circle one) Self Dad Mom Spouse Other: _______________
Policy Holder's Name (If other than self)	Policy Holder's Address (If other than self)

Policy Holder's Date of Birth	Policy Holder's Social Security Number	Policy Holder's Employer

I certify that the above information is true, correct and complete to the best of my knowledge. I hereby assign to Planned Parenthood of Maryland (PPM) the right to any claim or reimbursement for medical services provided by their physicians and clinical staff. I understand that I am responsible for any fees which are rejected by my insurance company and for which PPM received no payment. I also permit the copying and release of medical records to the insurance company for the processing of claims related to services provided. I understand that PPM is required to report to the appropriate government agencies if they suspect I am currently the victim of child abuse or neglect or if I indicate I was a victim of child abuse or neglect when I was a minor, even if I am now over age 18.

Client Signature: X____ **Date:** ____________________

Present Photo ID, Insurance Card and/or Proof of Income to Front Office Staff