

## CLIENT INFORMATION SHEET

Legal Last Name		Legal First Name		MI
What would you like to be called:				
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: _____		Where Did You Hear About Planned Parenthood: _____		
Type of envelopes we should use for mailings (Circle one) Planned Parenthood Logo Plain Envelope				
Social Security Number	Date of Birth	Required: Sex (Circle one) Male Female	Optional: Gender Identity (Circle one) Man Woman Other	
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)				
<input type="checkbox"/> American Indian	<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American		
<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian or Pacific Islander		
Hispanic Origin? (Circle one) Yes No				
Primary Language	Secondary Language	Marital Status (Circle one) Single Married Divorced		
<b>PRIMARY INSURANCE</b>				
Insurance Name		Policy Holder Relationship to you: _____		
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		
<b>SECONDARY INSURANCE (Fill in only if you have another insurance)</b>				
Secondary Insurance Name		Policy Holder Relationship to you: _____		
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**



Affix Label Here

Client's Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**VOLUNTARY REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES**

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 understand that I must tell the staff if language interpreter services are necessary to my understanding of the written or spoken information given during my health care visits. I understand that free interpretive services may not be immediately available and Planned Parenthood may need to refer me to another health care facility to provide the services necessary for my care.

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 described in Planned Parenthood of Maryland's *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.

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).

I hereby acknowledge receipt of Planned Parenthood of Maryland's notice of health information privacy practices.

Please note that Planned Parenthood of Maryland is a teaching institution, and that persons in training, under strict supervision, may be involved in some aspects of your care.

Signature of Client **X** \_\_\_\_\_ Date \_\_\_\_\_

I witness the fact that the client received the above mentioned information and said she/he read and understood same and had the opportunity to ask questions.

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

<input type="checkbox"/> <b>CHECK HERE IF CLIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW</b>	
Signature of any other person consenting <b>X</b> _____	Date _____
Relationship to client _____	
I witness the fact that the client'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 _____

*Client must review and sign PPMPF 112 every three years OR if the last consent signed was PPMPF 112, Rev 03/2007 or earlier.*

Affix Label Here

Client's Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**Limited Services History**

- Some of these questions are personal, but they help us in evaluating your health.
- If you have answered these questions on a previous visit & there is no change to your health history, please check the "no change" box in that section.

Reason for today's visit: _____		Age: _____	
<b>PAST MEDICAL HISTORY</b> <span style="float:right">No change since last visit</span>		<b>SOCIAL HISTORY</b> <span style="float:right">No change since last visit</span> <span style="float:right">♥</span>	
<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
	Are you allergic to: latex medication (please list) _____		Smoke cigarettes, cigars, pipes, or chew tobacco How much per day? _____
	Have you been under a provider's care for any illness or chronic condition? If yes, describe: _____		Drink alcohol (beer, wine, liquor) – _____ drinks per week
	Are you taking any medications (drugs, vitamins, over the counter medication, and herbal medication)? If yes, please list: _____ ♥		Do you or your partner use street or IV drugs?
<b>HOSPITALIZATIONS / SURGERIES</b> <span style="float:right">No change since last visit</span>			Do you feel like you should cut down or stop using alcohol/drugs?
<b>Year</b>	<b>Reason</b>	<b>UROGENITAL HISTORY</b>	
		_____ What was the first day of your last <b>normal</b> menstrual period? _____ Age periods started Periods come every _____ days and last _____ days. Please describe any problems you have had with your periods: _____	
		Is this your first genital/ pelvic exam? Yes No	
<b>Yes</b>	<b>No</b>	<b>Yes</b>	<b>No</b>
		<b>N/A</b>	<b>Do you have any of the following?</b>
	Do you hope to ever have (more) children? If yes, when? <input type="checkbox"/> More than one year <input type="checkbox"/> Less than one year <input type="checkbox"/> Unsure		<b>Breast</b> pain, lump or discharge
	Do you or your partner use birth control now? If so, what? _____ How long have you used this method? _____ If no method, why not?    trying to get pregnant partner(s) is same sex    other _____		Sores or bumps on or in genital area
	Are you happy with your current birth control method?		Itching or irritation of genitals
	Do you know about Emergency Contraception (EC) & that you can buy it without a prescription if you are ≥ 17 years old?		Unusual vaginal or penile discharge
			Pain with urination
			Unusual vaginal bleeding or bleeding with ejaculation
			Do you protect yourself from pregnancy? If yes, how? _____
			Date of last sex without a birth control method: _____
			Previous pregnancies? # pregnancies _____
			# children _____
			Previous ectopic (tubal) or molar pregnancy
			Do you think you might be pregnant now?
			Breastfeeding now?
			Genital trauma/surgery. Please explain: _____
			Bleeding or pain during or after sex
			Do you douche?
			Are you circumcised?
			Do you perform testicular self-exams?
<b>Please continue with form on back of this page →</b>			
<b>***Staff Use Only***</b> <b>HCA COMMENTS</b>			
<input type="checkbox"/> Hx Reviewed			
HCA Signature: _____		Date: _____	

♥ = **Babies Born Healthy:** These health issues are important for having a healthy baby as well as maintaining your own health.

Affix Label Here

Client's Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**Relationship & Safety**

*Violence and sexual abuse are common in many people's lives. There is help for you if you are being hurt or abused.  
(Note: PPM is required to report cases of child abuse or neglect that occurred as a minor, even if you are now over age 18.)*

Has your partner ever messed with your birth control or tried to get you pregnant when you didn't want to be?

Often  Sometimes  Never  Decline

Does your partner refuse to use condoms when you ask?

Often  Sometimes  Never  Decline

Has your partner ever tried to force of pressure you to become pregnant when you didn't want to be?

Often  Sometimes  Never  Decline

Are you afraid your partner will hurt you if you tell him or her you have an STI and he or she needs to be treated?

Often  Sometimes  Never  Decline

Have you ever been physically or emotionally abused by your partner or someone important to you?

Often  Sometimes  Never  Decline

Have you been hit, slapped, kicked or otherwise physically hurt by someone in the past year or, if you're pregnant, since you've been pregnant?

Often  Sometimes  Never  Decline

Has anyone forced you to have sex in the past year?  Often  Sometimes  Never  Decline

Are you afraid of your partner?  Often  Sometimes  Never  Decline

**FILL OUT THIS SECTION IF YOU ARE UNDER 18 YEARS OLD**

**Yes** **No**

Are your parent(s)/guardian(s) aware of your visit to Planned Parenthood of Maryland?

**CLIENT SIGNATURE**

**TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS COMPLETE AND CORRECT.**

**X** \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*\* Staff Use Only \*\*\***

**ADDITIONAL HCA COMMENTS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hx Reviewed HCA Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CLINICIAN COMMENTS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hx Reviewed Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_