

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



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.

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"/> CHECK HERE IF CLIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW	
Signature of any other person consenting X _____ 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 _____	

