

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 _____

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: _____

Birth Control Method Check

Reason for today's visit: _____ Age: _____

Are you still using your hormonal birth control method? Yes No

If not, when did you stop? _____ Why? _____

What birth control method are you using? _____

How long have you used this method? _____

What was the first day of your last menstrual period? _____

Was it normal (timing, amount of bleeding)? Yes No

Please indicate if you have had any of the following **since starting this method**:

Yes	No		Yes	No	
		Change in headaches			Nausea
		Chest pain			Severe abdominal pain
		Arm pain			Depression
		Leg pain			Yellowing of skin or eyes
		Visual changes			Bleeding between periods
		Numbness or tingly feeling			

Yes	No	
		Do you have questions about your method?
		Have you been late with or forgotten to use your contraception?
		Are you on any medication other than birth control? If yes, list: _____
		Have you or your partner had a new or more than one sexual partner in the past 3 months? # of partners you have had in past 12 months: _____ Partners are: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both <input type="checkbox"/> Trans
		Do you protect yourself from STIs? If yes, how? _____
		Do you smoke cigarettes, cigars, pipes, or chew tobacco? How much per day? _____
		Are you familiar with Emergency Contraception (EC) and that you can buy it without a prescription if you are ≥17 years old? Do you know when and how it can be used?

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?
		Are you in a relationship where you are being forced to have sex?

CLIENT SIGNATURE

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

Client Signature: **X** _____ Date: _____

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

SUBJECTIVE (HPI) – Extended HPI

HCA COMMENTS

Hx Reviewed HCA Signature: _____ Date: _____

CLINICIAN COMMENTS

Hx Reviewed Clinician Signature: _____ Date: _____

Affix Label Here

Client's Name: _____

DOB: _____ Date: _____

*** Staff Use Only ***

PAST / FAMILY / SOCIAL HISTORY

Medical History	Family History	Social History
<input type="checkbox"/> N/A (unless method change) <input type="checkbox"/> No Change <input type="checkbox"/> Changes include:	<input type="checkbox"/> N/A (unless method change) <input type="checkbox"/> No Change <input type="checkbox"/> Changes include:	<input type="checkbox"/> No Change <input type="checkbox"/> Changes include:

History reviewed from: Past History Form: Date: ___/___/___

(Method Check = "pertinent PFSH"; Method Change = "complete PFSH")

OBJECTIVE (PE)

Ht.	Wt.	BMI	BP	UPT: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> NA
<input type="checkbox"/> A & O x 3 <input type="checkbox"/> NAD <input type="checkbox"/> Apparent distress: _____			LABS SENT OUT: <input type="checkbox"/> Chlamydia <input type="checkbox"/> GC <input type="checkbox"/> Other _____	

ASSESSMENT

Yes	No	
		Appropriate to continue using _____; no contraindications
		Desires to change method to _____; no contraindications
		Appropriate for immediate use of EC
		Appropriate for STI screening
		Smoker?

Other:

Education Done &/or Literature Given

PLAN

<p>CIICs/CIIs provided in language other than English: <input type="checkbox"/> Spanish</p> <p><input type="checkbox"/> Nutrition _____ <input type="checkbox"/> Exercise</p> <p>Client Information for Informed Consents (CIICs)*</p> <p><input type="checkbox"/> The Pill <input type="checkbox"/> The Ring <input type="checkbox"/> The Patch <input type="checkbox"/> Special Considerations <input type="checkbox"/> DMPA <input type="checkbox"/> EC <input type="checkbox"/> POPs <input type="checkbox"/> Implants <input type="checkbox"/> IUC <input type="checkbox"/> IUC with Special Conditions <input type="checkbox"/> IUC Use Beyond Recommend. <input type="checkbox"/> IUC in Place-Pregnant <input type="checkbox"/> Misoprostol for GYN Procedures <input type="checkbox"/> RX Barriers</p> <p>Other CIICs: <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____</p>	<p>Client Information (CIs)*</p> <p><input type="checkbox"/> Male/Female Condoms <input type="checkbox"/> Preg Testing, Eval & Options <input type="checkbox"/> Spermicide for Birth Control <input type="checkbox"/> Smoking Cessation <input type="checkbox"/> Calcium & Vitamin D <input type="checkbox"/> Iron-Rich Foods <input type="checkbox"/> Tips for Losing Weight <input type="checkbox"/> Vaginal & Vulvar Health <input type="checkbox"/> Contra Choices <input type="checkbox"/> STI Facts <input type="checkbox"/> GYN Visit</p> <p>Other CIs: <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____</p> <p>*As of current year's MS&Gs</p>	<p><input type="checkbox"/> Problem List / Medication Record updated <input type="checkbox"/> Condoms offered/encouraged <input type="checkbox"/> Risks/benefits of BCM reviewed <input type="checkbox"/> DMPA <input type="checkbox"/> 104mg SQ/ <input type="checkbox"/> 150 mg IM q 12 wks x _____ <input type="checkbox"/> Given today <input type="checkbox"/> OCs _____ Sig: 1 qd x _____ # _____ today <input type="checkbox"/> NuvaRing PV X _____ days / out _____ days x _____ # _____ today, Refrigerate <input type="checkbox"/> Ortho Evra 1 patch/wk X 3, none for 1 wk x _____ # _____ today <input type="checkbox"/> Continue BCM as directed <input type="checkbox"/> Start: <input type="checkbox"/> Today <input type="checkbox"/> Day _____ p menses onset <input type="checkbox"/> Use BUM X 7 days <input type="checkbox"/> ECP _____: <input type="checkbox"/> 1.5 mg PO now. If no menses, repeat UPT in 2 wks. <input type="checkbox"/> May refill prn x 1 yr <input type="checkbox"/> Start BCM no later than following AM <input type="checkbox"/> If ≥40, mammogram/CBE encouraged <input type="checkbox"/> WWE encouraged – Due _____ RTC _____ for _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>If under 18, parental involvement <input type="checkbox"/> previously indicated <input type="checkbox"/> encouraged <input type="checkbox"/> Interpretation provided by PPM <input type="checkbox"/> Interpretation provided by client's preferred interpreter (_____) Total time spent with clinician: _____ <input type="checkbox"/> (Spent >50% of time counseling/education)</p> <p>Clinician Signature: _____ Date: _____</p>
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