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

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 _______________________

☐ **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.

Planned Parenthood® of Maryland, Inc.

Pregnancy Test Visit

Affix Label Here

Client's Name: ______________________________

DOB: ________________ Date: ________________

Reason for today's visit: ____ Age: ______

What was the first day of your last menstrual period? Date: ___________

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

My last period was: ☐ On time ☐ Early ☐ Late

The amount of bleeding was: ☐ Normal ☐ Lighter ☐ Heavier

Do you protect yourself from pregnancy? ☐ Yes ☐ No

If yes, how? _______________________

Date of last sex without a birth control method: _________________

Yes	No	
		Are your menstrual cycles usually monthly?
		Were you using a method of birth control when you think you may have become pregnant?
		Have you taken a home pregnancy test? If yes, when? ___________ Result: ______________
		Do you want to be pregnant? ☐ Undecided ☐ In the future
		Have you been pregnant before? If yes, # of live births ______ # of abortions ______ # of miscarriages ______ # of tubal pregnancies ______ # of still births ______
		If your pregnancy test is negative, would you be interested in starting on birth control? * ☐ Undecided ☐ Already on birth control ______________
		Since your last period have you had any bleeding or spotting? **
		Have you ever had pelvic inflammatory disease (**not** yeast, **not** bacterial vaginosis)? **
		Since your last period, have you had any **one-sided** abdominal pain? **
		Have you had a ruptured appendix? **
		Have you had a tubal ligation (tubes tied) or any other surgery on your tubes? **

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.)

My partner has threatened or frightened me.	☐ Often	☐ Sometimes	☐ Never	☐ Decline
My partner has physically abused me.	☐ Often	☐ Sometimes	☐ Never	☐ Decline
I have been forced to have sex.	☐ 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.

Client Signature: **X**____ Date: ______________________

HCA:
** Give client HOPE form, as needed*
*** If yes and positive pregnancy test, clinician must review form prior to client discharge. Give client PPMFS 211, CI: Ectopic Pregnancy, if directed by clinician.*

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

Affix Label Here

Client's Name: ______________________________

DOB: ________________ Date: ________________

SUBJECTIVE (HPI) – *Brief HPI*

HCA COMMENTS: ____

____

____

____

☐ Hx Reviewed ☐ New ☐ Est HCA Signature:____ Date:____________

CLINICIAN COMMENTS: ____

____

☐ Hx Reviewed Clinician Signature:____ Date:____________________

OBJECTIVE (PE)

LMP: _____________
UPT: ☐ Pos ☐ Neg ☐ Inconclusive
If positive, EGA by LMP ___________
EGA by bi-manual ___________
EDD ___________

☐ A & O x 3
☐ NAD
☐ Apparent distress:
____

LABS SENT OUT:
☐ Chlamydia
☐ GC
☐ Other __________________

ASSESSMENT

☐ Client desires to continue pregnancy
☐ Client desires to terminate pregnancy
☐ Client desires adoption
☐ Undecided
☐ Risk factors for ectopic pregnancy

☐ UPT Negative

PLAN

If pregnancy test was positive:

☐ Options discussed and info given for
- ☐ Prenatal care
- ☐ Abortion
- ☐ Adoption

☐ Provided info on early prenatal care, including folic acid
☐ Rx given for prenatal vitamins
☐ Reviewed signs and symptoms of ectopic pregnancy and miscarriage
☐ Birth control information given
☐ Condoms offered / encouraged

If pregnancy test was negative:

☐ Advised to repeat UPT in ____________
☐ Contraception options reviewed, including abstinence
☐ EC CIIC given **
☐ BCM (Contra Choices) information given
☐ Folic acid/prenatal vitamin info given
☐ Client encouraged to RTC for yearly exams, if appropriate
☐ HOPE appt offered
☐ Hope visit done today – see HOPE form
☐ Condoms use encouraged/offered
☐ If no unexplained menses x 3 months, advised follow-up
☐ Preconception counseling

CIICs/CIs provided in language other than English:
☐ Spanish

Other CIICs/CIs/Education:
☐ CIIC: Pregnancy Testing, Options Couns
☐ CI: Ectopic Pregnancy
☐ _________________

** As of current year's MS&Gs

Clinician Comments:

____

____

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____

☐ Reproductive Life Plan discussed

If under 18, parental involvement
☐ previously indicated ☐ encouraged

☐ Interpretation provided by PPM
☐ Interpretation provided by client's preferred interpreter (___________________)

Total time spent with clinician: _________
(☐ Spent >50% of the time counseling/education)

Signature:____________________________________

Date:_____________________