

## 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.*

**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)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
My last period was: <input type="checkbox"/> On time <input type="checkbox"/> Early <input type="checkbox"/> Late		
The amount of bleeding was: <input type="checkbox"/> Normal <input type="checkbox"/> Lighter <input type="checkbox"/> Heavier		
Do you protect yourself from pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Undecided <input type="checkbox"/> 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? * <input type="checkbox"/> Undecided <input type="checkbox"/> Already on birth control _____
		Since your last period have you had any bleeding or spotting? **
		Have you ever had pelvic inflammatory disease ( <b>not</b> yeast, <b>not</b> bacterial vaginosis)? **
		Since your last period, have you had any <b>one-sided</b> abdominal pain? **
		Have you had a ruptured appendix? **
		Have you had a tubal ligation (tubes tied) or any other surgery on your tubes? **
<b>RELATIONSHIP &amp; SAFETY</b>		
<i>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.)</i>		
Has your partner ever messed with your birth control or tried to get you pregnant when you didn't want to be? <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Decline		
Does your partner refuse to use condoms when you ask? <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Decline		
Has your partner ever tried to force of pressure you to become pregnant when you didn't want to be? <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> 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? <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Decline		
Have you ever been physically or emotionally abused by your partner or someone important to you? <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> 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? <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Decline		
Has anyone forced you to have sex in the past year? <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Decline		
Are you afraid of your partner? <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Decline		
<b>FILL OUT THIS SECTION IF YOU ARE UNDER 18 YEARS OLD</b>		
Yes	No	
		Are your parent(s)/guardian(s) aware of your visit to Planned Parenthood of Maryland?
<b>CLIENT SIGNATURE</b>		
TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS COMPLETE AND CORRECT.		
Client Signature: <b>X</b> _____ 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.

Affix Label Here

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

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

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

**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/CIIs provided in language other than English:
- Spanish
- Other CIICs/CIIs/Education:
- CIIC: Pregnancy Testing, Options Couns
  - CI: Ectopic Pregnancy
  - \_\_\_\_\_

Clinician Comments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Other:
- Safety Card Given
  - HPV Vaccine Information Given
  - Reproductive Life Plan discussed
  - 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: \_\_\_\_\_

**If under 18, parental involvement**  previously indicated  encouraged