

## 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 #	
<b>Emergency Contact Information</b>				
Emergency Contact Name	Relationship to You	Emergency Contact Phone #	Type of phone (Circle one) Home Work Cell Pager Other	
<b>Race Information</b>				
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		
<b>PRIMARY INSURANCE</b>				
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		
<b>SECONDARY INSURANCE (Fill in only if you have another insurance)</b>				
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"/> <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: \_\_\_\_\_

## Female Comprehensive History

Reason for today's visit: _____			Age: _____		
Some of these questions are personal, but they help us in evaluating your health.					
Yes, in the past	Yes, currently	No	<b>HOSPITALIZATIONS / SURGERIES</b>		
			Year	Reason	
<b>ALLERGIES</b>			<b>FAMILY HISTORY</b>		
1. Are you allergic to: <input type="checkbox"/> latex <input type="checkbox"/> medication (please list) _____			Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know my family history.		
<b>GENERAL</b>			Has your parent, sibling or grandparent had any of the following?		
2. Have you been diagnosed with Lupus?			Yes	No	<b>Diagnosis</b>
3. Have you been under a provider's care for any illness or chronic condition? If yes, describe: _____			<b>Relative</b>		
4. Are you taking any medications (drugs, vitamins, over the counter medication, and herbal medication)? If yes, please list: _____ ♥			Cancer (Breast, Ovarian, Uterine, Colon)		
<b>IMMUNIZATIONS</b>			Diabetes		
5. Hepatitis B <input type="checkbox"/> shot 1 <input type="checkbox"/> shot 2 <input type="checkbox"/> shot 3			Genetic Problems		
6. HPV <input type="checkbox"/> shot 1 <input type="checkbox"/> shot 2 <input type="checkbox"/> shot 3			High Blood Pressure		
7. Rubella/MMR			High Cholesterol or Fats		
8. Chicken Pox ( <input type="checkbox"/> Disease / <input type="checkbox"/> Vaccine)			History of Blood Clotting Disorders		
<b>CARDIOVASCULAR</b>			Other: _____		
9. High Blood Pressure ♥			<b>SOCIAL HISTORY</b> ♥		
10. High Cholesterol / Triglycerides			Yes	No	
11. Heart Disease/Murmur/Mitral Valve Problems ♥			<b>Nicotine, Alcohol, and/or Drug Use</b>		
<b>NEUROLOGIC</b>			Smoke cigarettes, cigars, pipes, or chew tobacco		
12. Stroke ♥			How much per day? _____		
13. Migraine *			Drink alcohol (beer, wine, liquor) -- _____ drinks per week		
14. Seizures/Epilepsy ♥			Do you or your partner use street or IV drugs?		
<b>GASTROINTESTINAL</b>			Do you feel like you should cut down or stop using alcohol/drugs?		
15. Irritable Bowel Syndrome or Crohn's Disease			<b>Exercise</b>		
16. Liver Disease / Jaundice / Hepatitis			Exercise _____ times per week for _____ minutes		
17. Gall Bladder Disease			<b>Relationship &amp; Safety</b>		
<b>ENDOCRINE</b> ♥			Violence and sexual abuse are common in many people's lives. There is help for you if you are being hurt or abused.		
18. Diabetes			(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.)		
19. Thyroid Problems			My partner has threatened or frightened me.		
<b>RESPIRATORY</b> ♥			<input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Decline		
20. Asthma / Tuberculosis / Chronic Cough			My partner has physically abused me.		
<b>GENITOURINARY</b>			<input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Decline		
21. Uterine Abnormality / Fibroids ♥			I have been forced to have sex.		
22. Endometriosis ♥			<input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Decline		
23. Pelvic Infection/Pain/PID ♥					
24. Breast Discharge / Lump					
<b>MUSCULOSKELETAL</b>			<b>Please continue with form on back of this page. →</b>		
25. Broken Bones / Osteoporosis			<b>*** Staff Use Only ***</b>		
<b>MENTAL HEALTH</b> ♥			<b>HCA COMMENTS</b>		
26. In Counseling			_____		
27. Depression / Anxiety / Bi-Polar			_____		
28. Suicide Attempt			_____		
29. Eating Disorder			_____		
<b>HEMATOLOGIC</b> ♥			_____ <input type="checkbox"/> Hx Reviewed		
30. Anemia			HCA Signature: _____ Date: _____		
31. Blood Clotting Disorder (Leg / Lung / Brain)			* Give client headache questionnaire.		
32. Sickle Cell Anemia / Trait / Thalassemia					

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

