

PLANNED PARENTHOOD GREATER MEMPHIS REGION

DEMOGRAPHIC DATA

Today's Date: _____ CHART NUMBER _____

Birthdate: _____

Last Name: _____ First Name: _____

Address: _____ City: _____

State: _____ Zip: _____ County: _____ Age: _____ SSN: _____

Sex: F / M Home Phone: _____ Cell Phone: _____ Wk Phone: _____

Race: White Black Native American Asian Pacific Islander Other	Ethnicity: Hispanic Non-Hispanic
Marital Status: Married Single Divorced Partnered	Education Level: _____
Occupation: _____	Employer: _____

How did you hear about us? (Please choose one)			
1-Other Clinic	2- Hospital/health agency	3-Private Doctor	4-Social/Church Agency
5-School	6-Other Patient	7-Family/Friend	8-Media
9-Hotline	10-Phonebook	11-Other Public Health Program	

Pregnancy Information:
Number of Pregnancies: _____
Number of Births: _____
Number of Living Children: _____

Emergency Contact:
Who should we contact in case of an emergency ONLY?
Name: _____
Relationship: _____ Phone: _____

<u>LAB TEST RESULTS – MUST BE COMPLETED</u>
Planned Parenthood MUST be able to contact you in certain situations. We also want to protect your privacy and confidentiality. If it is necessary to reach you for abnormal test results, what do you want us to say when calling? <input type="checkbox"/> Planned Parenthood OR <input type="checkbox"/> Dr's Office OR <input type="checkbox"/> Heather
What do you want us to say if we call your work number? <input type="checkbox"/> Planned Parenthood OR <input type="checkbox"/> Dr's Office OR <input type="checkbox"/> Heather
Can we mail a letter to you asking that you contact us? <input type="checkbox"/> Yes <input type="checkbox"/> No
Can the envelope have Planned Parenthood's return address on it? <input type="checkbox"/> Yes <input type="checkbox"/> No

If you DO NOT wish to be contacted at the above address and phone number: Who can we contact? _____ Relationship to you: _____ Their address: _____ Their phone: _____ We reserve the right to send a certified letter to the address you have given if that is the only way we can notify you of abnormal test results.
--

<u>MUST BE COMPLETED</u>
DO YOU HAVE HEALTH INSURANCE? YES NO PUBLIC OR PRIVATE INSURANCE NAME: _____

Place Patient Label Here

**REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES**

DATE _____ PATIENT # _____

NAME OF PATIENT _____

DATE OF BIRTH _____ TELEPHONE # _____

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), and 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 Greater Memphis Region'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).

Planned Parenthood Greater Memphis Region
2430 Poplar Ave, Suite 100
Memphis, TN 38112
(901) 725-1717

I hereby acknowledge receipt of Planned Parenthood Greater Memphis Region notice of health information privacy practices.

Signature of patient _____

Date _____

I witness the fact that the patient 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 PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY
REQUIRED TO SIGN BELOW

Signature of any other person consenting _____


Relationship to patient _____


Date _____

I witness the fact that the patient'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 _____



GREEN CHOICES |  Planned Parenthood

Environmental Health Assessment Form

Every day, we eat, drink, breathe, and touch chemicals that exist around us. This assessment will help you identify some of your exposure to common chemicals. Planned Parenthood GREEN CHOICES and our staff will then give you the information you need to make choices for better health and a greener environment — for yourself, your family, and your community.

To be completed by staff:
 Staff name _____
 Chart number _____

Name _____ Today's date _____

INSTRUCTIONS: Circle your response for each statement below.

1. Tell us about the food you eat.

I eat fish and/or seafood.	Regularly	Sometimes	Never
I eat meat and/or poultry (chicken, turkey, etc.)	Regularly	Sometimes	Never
I eat fruits and/or vegetables.	Regularly	Sometimes	Never
I eat <i>organic</i> fruits and vegetables.	Regularly	Sometimes	Never

2. Tell us about the things you use when cooking, eating, or storing food.

I microwave my food in plastic containers or use plastic wrap.	Regularly	Sometimes	Never
I (or my family) eat food that comes from a can (soups, beans, baby formula, etc).	Regularly	Sometimes	Never
I (or my family) drink from plastic bottles or cups.	Regularly	Sometimes	Never
I store food in plastic.	Regularly	Sometimes	Never
My take-out comes in plastic.	Regularly	Sometimes	Never

3. Tell us about the personal care products you use.

I use personal care products with fragrance (smell), like lotion or soap.	Regularly	Sometimes	Never
I chemically straighten, relax, highlight, perm, or dye my hair (on head or body).	Regularly	Sometimes	Never
I use cosmetics such as perfume/cologne, lipstick, nail polish, or mascara.	Regularly	Sometimes	Never

4. Tell us about where you live. (This can be your house, dorm, apartment, or other living quarters).

My home was built before 1978.	Yes	No	I don't know
My home was tested for lead.	Yes	No	I don't know
There is shower mold or mildew in my home.	Yes	No	I don't know
There are working smoke detectors in my home.	Yes	No	I don't know
There are working carbon monoxide detectors in my home.	Yes	No	I don't know

5. Tell us about the types of chemicals around you.

Pesticides are used at my home and/or work (pesticides are chemicals used to kill bugs, rodents, and/or weeds).	Regularly	Sometimes	Never
Flea collars, dips, or other chemicals are used on my pets. <i>(leave blank if you do not have pets)</i>	Regularly	Sometimes	Never
I live and/or work near a farm, park, or golf course.	Yes	No	

6. Tell us about the cleaning products you use at home or at work.

I use and/or work with strong-smelling cleaning products.	Regularly	Sometimes	Never
I use different cleaning products at the same time (such as bleach and ammonia).	Regularly	Sometimes	Never
I use air fresheners, plug-ins, scented candles, or incense.	Regularly	Sometimes	Never

7. Tell us about smoking (cigarettes, cigars, or pipes).

I smoke.	Regularly	Sometimes	Never
I smoke inside my home or car.	Regularly	Sometimes	Never
Other people smoke around me.	Regularly	Sometimes	Never
My children are exposed to smoke from others. <i>(Leave blank if you do not have children.)</i>	Regularly	Sometimes	Never

THE FOLLOWING SECTION WILL HELP YOUR HEALTH CARE PROVIDER TO BETTER GUIDE YOU.

Tell us about your or your partner's pregnancy plans and any children you already have.

I (or my partner) am currently pregnant.	Yes	No	I don't know
I (or my partner) am thinking about getting pregnant in the next 12 months.	Yes	No	I don't know
I currently have one or more children living with me.	Yes	No	
If Yes to the above: I have children under the age of six living with me.	Yes	No	

If you have questions related to environmental health, please write them down for your health care provider to answer:
