

Planned Parenthood Association of the Mercer Area

Patient Registration Form Regestación Para Paciente

Patient#/# del paciente _____

**Please complete the following form. All the information is confidential.
Por favor complete la hoja seguida. Toda la información es confidencial.**

First Name Primer Nombre _____	Last Name Apellido _____
Address Dirección _____	County Condado _____
City Ciudad _____	State Estado _____
SS# # de Seguro Social _____	Date of Birth Fecha de Nacimiento ____/____/____
	Zip Código Postal _____

House Hold Income Ingreso de la casa \$ _____	Yearly <input type="checkbox"/> Anual	Monthly <input type="checkbox"/> Mensual	Weekly <input type="checkbox"/> Semanal
Family Size Cuantos son en tu Familia _____	How many are children(s) Cuantos son niño(s) _____		

Home phone Numero de teléfono (____)____-____	Work phone Numero del trabajo (____)____-____
Emergency contact Phone number Numero de contacto de emergencia (____)____-____	Emergency contact Name Nombre del contacto de emergencia _____

Please check one of the four ways you want to receive you mail from us (PPAMA)
Por favor marque una de las cuarto maneras que tu querré recibir correspondencia de nosotros (PPAMA)

Full return address <input type="checkbox"/> Dirección completa dé retorno	Street address ONLY <input type="checkbox"/> Solamente la dirección de la calle	NO return address <input type="checkbox"/> SIN dirección	NO mail <input type="checkbox"/> Ninguna respeta
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Please check one of the four ways you want to receive phone calls from us (PPAMA)
Por favor marque una de las cuarto maneras que tu querré recibir llamas de nosotros (PPAMA)

Saying Planned Parenthood <input type="checkbox"/> Diciendo Planned Parenthood	Saying Doctor's Office <input type="checkbox"/> Diciendo oficina de doctor	Saying it's a friend <input type="checkbox"/> Diciendo que es una amiga	NO calls <input type="checkbox"/> Ninguna llamadas
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Please check all that apply
Por favor marque todo que aplica

Sex	Female	Male				
Sexo -	<input type="checkbox"/> Femenino	<input type="checkbox"/> Masculino				
Race	American Indian or Alaskan Native	Asian	Black or African American	Native Hawaiian or Pacific Islander	White	
Raza -	<input type="checkbox"/> Indio Americano o Nativo de Alaska	<input type="checkbox"/> Asiático	<input type="checkbox"/> Moreno o Americano Africano	<input type="checkbox"/> Nativo Hawaiano o Isleño Pacifico	<input type="checkbox"/> Blanco	
Hispanic	Yes - Hispanic or Latin	Not - Hispanic nor Latin	Unknown			
Hispano -	<input type="checkbox"/> Si - Hispano o Latino	<input type="checkbox"/> No - Hispano o Latino	<input type="checkbox"/> No sabes			
Marital Status	Divorced	Living together	Married	Separated	Single	Widowed
Estado Marital -	<input type="checkbox"/> Divorciada	<input type="checkbox"/> Viven juntos	<input type="checkbox"/> Casada	<input type="checkbox"/> Separada	<input type="checkbox"/> Soltera	<input type="checkbox"/> Viuda
Referral	Family o Friend	Hospital	Hot Line	Media	Other patient	Phone book
Referido -	<input type="checkbox"/> Familia o Amiga	<input type="checkbox"/> Hospital	<input type="checkbox"/> Línea Abierta	<input type="checkbox"/> Medio de comunicación	<input type="checkbox"/> Otra paciente	<input type="checkbox"/> Libro de teléfono
	Outreach	Private Doctor	Welfare			
	<input type="checkbox"/> Alcance	<input type="checkbox"/> Médico privado	<input type="checkbox"/> Welfare			
Language	English	Other	Interpreter Needed			
Idioma -	<input type="checkbox"/> Ingles	<input type="checkbox"/> Otro _____	<input type="checkbox"/> Necesito un Interprete			
Student	Yes	No	Highest grade f school you completed			
Estudiante -	<input type="checkbox"/> Si	<input type="checkbox"/> No	Grado mas alto que ha completado en la escuela _____			

Chlamydia/Gonorrhea/HIV Screening Visit

Date:

PLEASE COMPLETE THE FOLLOWING QUESTIONS

Symptoms of Gonorrhea and Chlamydia

There are usually no symptoms. But if they are present, they may feel like:

Women: unusual vaginal discharge, burning with urination, lower abdominal or low back pain, pain with sex, or bleeding after sex or between periods.

Men: discharge from the penis, a burning sensation with urination, or burning and itching around the opening of the penis

Check below:

- Yes No Was your sex partner(s) recently treated for chlamydia or gonorrhea?
- Yes No Is you sex partner(s) having any of the symptoms listed above?
- Yes No Are you having any of the symptoms listed above?
- Yes No Are you allergic to any medicines? If yes, please list: _____

Female Clients Only : When was your last period? _____

Client's Signature

Date

FOR STAFF ONLY – DO NOT WRITE BELOW THIS LINE

- Yes No Client reports symptoms. Appt. offered. Declined Scheduled Appointment for:
- CI HIV given.
- Rapid HIV test done. Oral / Blood Results: Negative Positive Confirmatory test sent. Client informed.
- Urine GC/CT sent.

Notes:

Staff signature

Date

- | | |
|--|---|
| <p>Plan:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Treat today. <input type="checkbox"/> NKDA <ul style="list-style-type: none"> <input type="checkbox"/> Azithromycin 1 gm orally in single dose <input type="checkbox"/> Cefixime 400 mg orally in single dose <input type="checkbox"/> Other _____ <input type="checkbox"/> Medication CIs given. <input type="checkbox"/> Package inserts given. <input type="checkbox"/> Await results. <input type="checkbox"/> Other _____ <p>Notes:</p> | <ul style="list-style-type: none"> <input type="checkbox"/> Provide partner treatment today. <input type="checkbox"/> NKDA <input type="checkbox"/> Unknown <ul style="list-style-type: none"> <input type="checkbox"/> Azithromycin 1 gm orally in single dose <input type="checkbox"/> Cefixime 400 mg orally in single dose <input type="checkbox"/> Other _____ <input type="checkbox"/> Partner treatment CIs given. <input type="checkbox"/> Package inserts given. <input type="checkbox"/> Refer partner for treatment. <input type="checkbox"/> PP <input type="checkbox"/> other |
|--|---|

Clinician signature

Date

FOR STAFF ONLY – DO NOT WRITE BELOW THIS LINE

Results:

- GC Negative Positive
 CT Negative Positive
 Confirmatory HIV Negative Positive Not done

Plan, if any positives:

- Treat. NKDA Treated at visit.
 Azithromycin 1 gm orally in single dose
 Cefixime 400 mg orally in single dose
 Other _____
 Partner treatment.
 Azithromycin 1 gm orally in single dose
 Cefixime 400 mg orally in single dose
 Other _____
 Refer partner for treatment. PP other
 Refer for HIV care.

Notes:

 Clinician Signature Date

Notification attempts:

	Date	Initial	Response
1. TC – H W ER C			NA LM DC
2. Letter _____			
3. Letter _____			

Notes:

 Staff Signature Date

Treatment:

- Client picked up medication. Date: _____
 For self. Lot # (s): _____
 Medication CIs given. Package inserts given.
 Partner treatment Letter Given
 Prescription called into pharmacy. Tel # _____

 Staff Signature Date

Reminder : Not applicable

1. Letter _____ or			
TC – H W ER C			NA LM DC

TC – Telephone Call, H- Home, W- Work, ER- Emergency #, C- Cell, NA – no answer, LM – left message, DC- disconnected