

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

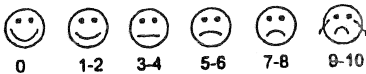
ASSURANCE OF CONFIDENTIALITY: This medical record is confidential and will not be released to anyone without your written consent except as may be required by law.

ANNUAL/REVISIT HISTORY / MALE

Date: _____

Allergies: _____

Reason for today's visit: _____

Y e s	N o	Medical History Are you experiencing?	Staff Use Only	Y e s	N o	Current Health Practices Do You
		2. Pain, burning or difficulty with urination?			13. Use alcohol: Amount/week _____	
		3. Frequent urination or blood in urine?			14. Use street drugs: Type _____	
		4. Pain or bleeding with sex or ejaculation?			SINCE YOUR LAST VISIT HAVE YOU HAD:	
		5. Rectal pain, bleeding or discharge?			15. Illness, surgery, hospitalization	
		6. Bumps or sores on your penis or genital area?			16. Jaundice (yellow skin or eyes), hepatitis, mononucleosis	
		7. Have you recently taken antibiotics for infection?			17. Any changes in the health of close family members? (heart attack, stroke, diabetes, cancer, cholesterol, death)	
		8. Have you or your partner had more than one sexual partner in the past three months?			18. Are you allergic to any medicine? What: _____	
		9. Has your partner(s) had bumps, sores or discharge in genital area?			19. Are you in pain today? Please circle re: severity 	
		10. Has your partner recently been treated for a sexually transmitted disease?				
		11. Are you using condoms for every sex act?			Location of today's pain	

Please list all medications or drugs you are using now or take frequently, including over-the-counter medications, herbs and vitamins _____

To the best of my knowledge, the above information is complete and accurate.

Client signature: _____

Date: _____

Physician Signature: _____

Date: _____

