

PATIENT INFORMATION

PERSONAL INFORMATION

Acct# _____

Name: (Last, First, Middle) _____

Preferred Name: (Nickname, Middle name, etc.) _____

Address: (No. Street) _____ Apt # _____

City: _____ State: _____ Zip: _____ County: _____

Preferred Telephone#: _____ Alternate Telephone#: _____
please circle (day, evening, cell) please circle (day, evening, cell)

Sex: ___ Age: _____ Date of Birth: _____ City/State of Birth: _____

Marital Status: _____ Race(s) list all that apply: _____

EMPLOYMENT INFORMATION

EMPLOYED: FULL-TIME: _____ PART-TIME: _____ NOT WORKING _____

If not working, how are you supporting yourself? _____

MONTHLY INCOME: \$ _____ # OF PEOPLE SUPPORTED: _____

INSURANCE INFORMATION

Do you have insurance? **Y/N** If yes, which one? _____

ID # _____

Are you the policy holder (is the insurance through your work or under your name)? **Y/N**

If you are not the policy holder, who is? (please write name, DOB and relationship) Name _____

_____ DOB _____ Relationship _____

Have you had Medicaid within the last 2 yrs? **Y/N**

CONTACT INFORMATION

*If any of your test results are abnormal, we **MUST** be able to reach you!*

If we call you, can we say we are Planned Parenthood? _____ YES _____ NO

If we send you mail, can it be in a Planned Parenthood envelope? _____ YES _____ NO

If you choose to use insurance, you cannot choose to be a confidential contact.

If you checked "No" to the above two questions, please give us an alternate mechanism for us to contact you.

Name of contact: _____ Relationship to you: _____

Address: _____ Telephone Number: _____

(Please note: if we use your alternate contact, we will identify ourselves as Planned Parenthood)

(OVER)

EMERGENCY CONTACT INFORMATION

We need a contact person in case of an emergency while you are in our health center. (The person MUST be 19 years of age or older.)

NAME: _____ RELATIONSHIP: _____ PHONE: _____

SCHOOL INFORMATION

HIGHEST GRADE COMPLETED: (Please Circle) 9, 10, 11, 12, 13, 14, 15, 16 OTHER_____

STUDENT STATUS: FULL-TIME: _____ PART-TIME: _____ NOT A STUDENT: _____

REFERRAL INFORMATION

How did you find out about us? Friend____ Radio____ Bus/Subway____ TV____ Doctor/Social Worker____ Planned Parenthood Program____ Internet____ Magazine____ Newspaper____ Relative____ School____ Yellow Pages____ Movies____

PATIENT CONSENT

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:

I voluntarily consent to the necessary procedures and medications needed for the care I have requested.

I authorize the release of any medical or other information necessary to process an insurance claim. I also request payment of government benefits either to myself or the party who accepts assignment below if I have government insurance.

I understand that Medicaid is the Payer of Last Resort (PLR) and that if I have Medicaid and another insurance - in which Planned Parenthood participates, that I must use the other insurance first. I attest that the insurance information I provided was accurate and complete to the best of my knowledge.

I understand that if I would like to designate a health care proxy, I should request a proxy form from a Planned Parenthood staff person.

SIGNED: _____ DATE: _____

RELATION TO PATIENT: _____ DATE: _____

STAFF WITNESS: _____ DATE: _____

Patient Picture ID checked

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