

PATIENT INFORMATION

PERSONAL INFORMATION

Name: (Last, First, Middle) _____

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

Address: (No. Street) _____ Apt # _____

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

Home Telephone#: _____ Cell #: _____ Work # _____

Date of Birth: _____ Age: ____ Sex: ____ City/State of Birth (or Country): _____

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

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

INSURANCE INFORMATION

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

ID # _____

If you choose to use insurance, and there is a problem with the insurance or payment, we may send you mail in an envelope that says PLANNED PARENTHOOD.

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

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

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: _____

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: _____

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 ____

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 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)

*If you are using insurance, the insurance company will send an EOB (Explanation of Benefits) to **the insured**. The EOB will likely state the procedures that were performed and the place of service – Planned Parenthood of Nassau County.

ADDITIONAL INFORMATION

Planned Parenthood of Nassau County encourages you to utilize our secure, confidential, **Patient Portal** to access test results, receive appointment reminders and view previous appointments. If you would like to utilize the portal, please provide us with your email address:

Email address: _____

Planned Parenthood of Nassau County would also like to know your pharmacy name and address so that we can send prescriptions electronically (which is quicker and more efficient). Please provide us with your pharmacy information:

Pharmacy Name: _____ Pharmacy Address: _____

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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