



Planned Parenthood® of Central Ohio, Inc.

Planned Parenthood® of Southeast Ohio, Inc.
Planned Parenthood® of Northwest Ohio, Inc.
Central Ohio Women's Center, Inc.

206 East State Street
Columbus, Ohio 43215
614-224-2235 / 800-230-7526

REGISTRATION SHEET – PLEASE PRINT

Please be sure you fill in this form correctly & completely, sign & date at the bottom.

Your privacy is just as important to Planned Parenthood (PP) as your health care. Your contact information will be used by PP if we need to get in touch with you about your test results, for appointment reminders, or to send a monthly statement if you have an outstanding balance. If you do not answer our calls or letters regarding an abnormal test, we will also try to reach you through your emergency contact below. We will be as careful as possible to protect your confidentiality, and will make *every reasonable effort* not to reveal the details of the situation to anyone except you.

YOUR LAST NAME		FIRST NAME		MI		
YOUR MAILING ADDRESS		APT #	CITY	COUNTY	STATE	ZIP CODE

If you do not want us to contact you at the above address, please give us a mailing address where it is ok to send bills and to contact you about test results and insurance information. This does not have to be your home address.

PREFERRED/ALTERNATE MAILING ADDRESS		APT #	CITY	COUNTY	STATE	ZIP CODE
-------------------------------------	--	-------	------	--------	-------	----------

If you have any concerns about us mailing things to you, please let one of our front desk staff know and we would be happy to discuss this with you.

PLEASE ✓ WHICH NUMBER IS THE BEST ONE FOR US TO CALL

<input type="checkbox"/> YOUR HOME PHONE ()	<input type="checkbox"/> YOUR WORK PHONE ()	<input type="checkbox"/> YOUR CELL PHONE ()
<i>When calling me, PP staff should:</i>		
<input type="checkbox"/> Identify themselves as Planned Parenthood <input type="checkbox"/> Identify themselves only as my "doctor's office."		

Who should we contact in case of an emergency? Phone #: _____

Name: _____ **Relationship:** _____

YOUR SOCIAL SECURITY #	YOUR DATE OF BIRTH / /	YOUR GENDER <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	YOUR MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married
YOUR RACE <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> Multiracial	<input type="checkbox"/> Black (African-American) <input type="checkbox"/> White (Caucasian) <input type="checkbox"/> Other	YOUR ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic
BIRTH CONTROL YOU USE NOW			

HIGHEST GRADE COMPLETED (1-16)	I HAVE A: <input type="checkbox"/> High school diploma <input type="checkbox"/> GED <input type="checkbox"/> Neither	ARE YOU A STUDENT NOW? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES: <input type="checkbox"/> PART-TIME <input type="checkbox"/> FULL TIME	NUMBER OF CHILDREN BORN TO YOU THAT ARE LIVING NOW
-----------------------------------	---	--	--	--

Do you need an interpreter? No Yes **What language?** _____

PATIENT SIGNATURE _____ TODAY'S DATE _____

FOR OFFICE USE ONLY Entered by (staff initials): _____ Date _____ eMedsys acct# _____											
STAFF: INITIAL EACH MONTH WHEN INFO HAS BEEN REVIEWED											
JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC