

Patient Information

Last Name:		First Name:		MI	
Street Address:				Social Security #	
City:		State:		Zip Code:	
*Home Phone:	()	*Work Phone:	()	*Cell Phone:	()
E-mail:			Date of Birth:		

Gender	Marital Status	Preferred Language	Ethnicity	FOR TITLE X SITES ONLY
<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgendered	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	HISPANIC <input type="checkbox"/> & American Indian <input type="checkbox"/> & Asian <input type="checkbox"/> & Black or African <input type="checkbox"/> & Hawaiian or Pacif. <input type="checkbox"/> & White NON-HISPANIC <input type="checkbox"/> & American Indian <input type="checkbox"/> & Asian <input type="checkbox"/> & Black or African <input type="checkbox"/> & Hawaiian or Pacif. <input type="checkbox"/> & White	Income per Month: Family Size:

PATIENT CONTACT INFORMATION:	<p>We will contact you regarding any testing and medical care that you receive at Planned Parenthood, as well as about any outstanding account balances. It is important that we are able to reach you. If we need to contact you and can not reach you at home or at work, we will use your emergency contact information. *Please be aware that if you have caller ID and do not accept blocked calls, Planned Parenthood's name and phone number may appear on your screen.</p> <p>If we call you, may we say, "Planned Parenthood is calling"?</p> <p>Home: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Please say "the doctor's office is calling" (If "no", we will say "Mindy Smith is calling.") Cell: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Please say "the doctor's office is calling" (If "no", we will say "Mindy Smith is calling.") Work: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Please say "the doctor's office is calling" (If "no", we will say "Mindy Smith is calling.")</p> <p>Where should we send mail regarding medical results, notifications and financial statements? <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other</p> <p>If we cannot send you a letter at home or work, where can we send it & to whom should we address it?</p> <p>Address: City: State: Zip Code:</p>
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EMERGENCY CONTACT INFORMATION:	Name _____ Relationship to you: _____ Phone: _____ Address: _____ City: _____ State: _____ Zip: _____
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INSURANCE INFORMATION:	<p>Please complete below and provide your insurance card for our records.</p> <p>Who is your health insurance carrier?</p> <p>Whose insurance is it? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Spouse <input type="checkbox"/> Guardian <input type="checkbox"/> Other</p> <p>Name of Insured: Date of Birth of the Insured:</p> <p>Address: City: State: Zip:</p> <p>Policy number of Insured: Place of employment of the Insured:</p> <p>Are you are covered by an additional policy? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide the information to our staff.</p> <p><i>My signature on this form permits Planned Parenthood Arizona to release medical information to my insurance carrier for billing purposes related to my claim.</i></p>
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Employment
<input type="checkbox"/> Active Duty <input type="checkbox"/> Full-time <input type="checkbox"/> Not Employed <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Self employed

Student Status
<input type="checkbox"/> Full-time <input type="checkbox"/> Not Student <input type="checkbox"/> Part-time

Referral Source
<input type="checkbox"/> Friend/colleague <input type="checkbox"/> Newspaper <input type="checkbox"/> Family member <input type="checkbox"/> TV/Radio <input type="checkbox"/> Yellow pages <input type="checkbox"/> Website/e-mail <input type="checkbox"/> UA Wildcat <input type="checkbox"/> Flyer/brochure <input type="checkbox"/> PCC Aztec Press <input type="checkbox"/> Event or presentation <input type="checkbox"/> Rubyfruit <input type="checkbox"/> UA Campus Link Display <div style="text-align: right;"><i>Other (list below)</i></div>

PATIENT SIGNATURE: _____ **DATE:** _____