

DATE \_\_\_\_\_

**INTAKE FORM**

Please complete *both sides* of this form as accurately as possible.

\_\_\_\_\_  
Last Name First Name Middle initial

\_\_\_\_\_  
Street Address Apt#

\_\_\_\_\_  
City State Zip Code

Is it okay to send mail to you at this address in a Planned Parenthood envelope? **YES NO**

**If no**, can we send mail to this address if we use only a PO Box as our return address? **YES NO**

**If no**, please give us another address where we may send mail to you:

\_\_\_\_\_  
Street Address Apt#

\_\_\_\_\_  
City State Zip Code

Planned Parenthood envelope ok  PO box as return address only

**Contact phone:** \_\_\_\_\_ ( Home  Work  Cell)

Call as? (Please check one)  Planned Parenthood  Doctors office  Peggy

**Other phone:** \_\_\_\_\_ ( Home  Work  Cell)

Call as? (Please check one)  Planned Parenthood  Doctors office  Peggy

**Important! Should a life threatening condition be suspected or detected, confidentiality may need to be broken if you cannot be reached using the instructions you have given to us.**

**IN CASE OF EMERGENCY WHILE YOU ARE IN OUR OFFICE we can contact**

**Name** (First) \_\_\_\_\_ (Last) \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Relationship to you:** \_\_\_\_\_

<b>Social Security #</b> _____ - _____ - _____	<b>Date of Birth</b> _____ / _____ / _____ <small>Month Day Year</small>	<b>Age:</b> _____	<input type="checkbox"/> <b>Female</b> <input type="checkbox"/> <b>Male</b>
<b>Gross (before taxes) household (anyone over 18 should be included) weekly income:</b> \$ _____  <b>Family size</b> (number of people supported by that income): _____		<b>County you live in:</b> <input type="checkbox"/> Bucks <input type="checkbox"/> Montgomery <input type="checkbox"/> Philadelphia <input type="checkbox"/> Other _____	

<b>Race:</b> <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black/ African American <input type="checkbox"/> Multiple Race <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Unknown / other <input type="checkbox"/> White	<b>Language:</b> English language proficient? <input type="checkbox"/> YES <input type="checkbox"/> NO Do you need an interpreter? <input type="checkbox"/> YES <input type="checkbox"/> NO  If yes, what Language? _____	<b>Student status:</b> <input type="checkbox"/> Not a student <input type="checkbox"/> Part-time student <input type="checkbox"/> Full-time student What is the Highest grade you have completed? _____
<b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		
<b>Current Contraceptive (Birth control) method:</b> <input type="checkbox"/> None <input type="checkbox"/> Abstinence (Not having sex) <input type="checkbox"/> Birth Control Pills <input type="checkbox"/> Cervical Cap <input type="checkbox"/> Condom—female <input type="checkbox"/> Condom—male <input type="checkbox"/> Depo-Provera (Depo) (the shot) <input type="checkbox"/> Diaphragm <input type="checkbox"/> Fertility Awareness (FAM) <input type="checkbox"/> Foam & Condom <input type="checkbox"/> Implanon <input type="checkbox"/> IUD <input type="checkbox"/> Norplant <input type="checkbox"/> Other method <input type="checkbox"/> Patch (Ortho-Evra) <input type="checkbox"/> Spermicide <input type="checkbox"/> Sponge <input type="checkbox"/> Sterilization (Vasectomy or Tubal Ligation) <input type="checkbox"/> Unknown <input type="checkbox"/> Vaginal Ring (NuvaRing)		

**Health Insurance information: (If you have insurance, please bring your card to the front desk now.)**

- Not covered by any health insurance
- Commercial Medical Insurance
- MA Access Card
- Select Plan

**ALL PATIENTS MUST READ AND COMPLETE THIS SECTION:**

You may be eligible to have all or part of your services subsidized (paid for) through Planned Parenthood or government funds. In order to determine if you are eligible, you must provide us with information about your household size and income. Please check (√) "A" below if you wish to provide this information. If you do not wish to provide this information and be assessed for eligibility for a reduced fee, check option "B" below.

**A.** I wish to provide eligibility information for possible reduced fees. I understand that many of the medical/family planning services are available on a sliding fee scale, based on eligibility information, and I am voluntarily requesting these services. To the best of my knowledge, all eligibility information is true and complete. I agree to report to the agency immediately any changes in circumstances. I agree to provide documentation of eligibility factors, if required. I understand that I can request to have my eligibility reviewed if I do not agree with it. **I understand that if I am assessed as eligible for free services at this visit, this does not mean that I will never have to pay for my services in the future -- all patients are reassessed periodically for eligibility.**

**B.** I want to pay the full fee for my healthcare & decline to provide eligibility information for subsidized services.

**The information I have provided above is correct and complete to the best of my knowledge.**

**Client signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Staff witness signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_