Planned Parenthood®
Association of Bucks County

Date:_______________

INTAKE FORM

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

How did you hear about us?	
❑ Advertisement: ❑ Movie Theater (then went to Web site) ❑ Newspaper ❑ Magazine	❑ Web site ❑ Google/Internet Search ❑ Friend/relative ❑ Social Service Agency ❑ Other:

★**Please check one:** I am ❑ a new patient ❑ an established patient.

Last Name First Name Middle Initial

Street Address Apt. #

City County State Zip code

Is it ok 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 a PO Box as our return address? ❑ Yes ❑ No

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

Street Address Apt. #

City County State Zip code

Phone:_______________(❑Home ❑Work ❑Cell) **Other:**_____________ (❑Home ❑Work ❑Cell)

Call as? (Please check one) ❑ Planned Parenthood ❑ Doctor's office ❑ Peggy

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

★IN CASE OF EMERGENCY WHILE YOU ARE IN OUR OFFICE WE CAN CONTACT:

First Name Last Name

Relationship to you Phone Number

Social Security # ______ -_____ - _______	Date of Birth Age: ______ ______/_____/______ Month Day Year	☐ Female ☐ Male
Gross (before taxes) household (anyone over 18 should be included) weekly income: $______________ Family size (number of people supported by your household income): __________________		

Race:	**Language:**	**Student status:**
❑ Native American ❑ Asian ❑ Black/ African American ❑ Multiple Race ❑ Native Hawaiian/Pacific Islander ❑ White ❑ Hispanic	Proficient in English Language? ❑ YES ❑ NO Do you need an interpreter? ❑ YES ❑ NO If yes, which language? __________________________	☐ Not a student ☐ Part-time student ☐ Full-time student What is the highest grade you have completed? ______________________________

Current Contraceptive (Birth control) method:

- ❑ None
- ❑ Abstinence (Not having sex)
- ❑ Birth Control Pills
- ❑ Cervical Cap
- ❑ Condom – female
- ❑ Condom – male
- ❑ Depo-Provera (Depo) (the shot)
- ❑ Diaphragm
- ❑ Fertility awareness (FAM)
- ❑ Foam & Condom
- ❑ Implanon
- ❑ IUD/IUC
- ❑ Norplant
- ❑ Other method
- ❑ Patch (Ortho-Evra)
- ❑ Spermicide
- ❑ Sponge
- ❑ Sterilization (Vasectomy or Tubal Ligation
- ❑ 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
❑ MA Access Card
❑ Other MA Insurance
❑ Commercial Medical Insurance
❑ SelectPlan for Women

<u>ALL PATIENTS MUST READ AND COMPLETE THIS SECTION:</u>

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:**_______________