Planned Parenthood® Golden Gate

CLIENT REGISTRATION FORM

CONTACT INFORMATION: Accurate contact information is necessary for us to notify you of any abnormal medical findings. You must give us some way to contact you. If a phone call is necessary, we can identify ourselves as "Toni" rather than as PPGG.

Patient Information

Last Name:________________________________

First Name:________________________________

Middle Name:______________________________

Nickname:_________________________________

Social Security Number: _ _ _ - _ _ - _ _ _ _

Birth Date: _ _ / _ _ / _ _ _ _

Sex: ☐ Female ☐ Male ☐ Transgender

Address:__________________________________

____

City:_____________________________________

State:___________________ Zip Code: _ _ _ _ _

Home Phone: (_ _ _) _ _ _ - _ _ _ _

Day Phone: (_ _ _) _ _ _ - _ _ _ _

Email (optional):__________________________

Emergency Contact

Phone: (_ _ _) _ _ _ - _ _ _ _ Name:_________________________ Relationship:__________________

Contact Preferences

How can you receive mail from PPGG? ☐ In a PPGG envelope ☐ In a plain envelope

If we need to call you how should we identify ourselves? ☐ PPGG ☐ Dr's Office ☐ Toni

Would you like to receive email from PPGG regarding new services, news, and events? ☐ Yes ☐ No

Demographic Information: Please check only one box in each column.

Race
- ☐ White
- ☐ African American
- ☐ Asian
- ☐ Asian - Filipino
- ☐ Pacific Islander
- ☐ Native American
- ☐ Multi-racial
- ☐ Other:___________

Ethnicity

Do you consider yourself to be Hispanic or Latino?
- ☐ Yes
- ☐ No

Primary Language
- ☐ English
- ☐ Spanish
- ☐ Chinese
- ☐ Tagalog
- ☐ Cantonese
- ☐ Vietnamese
- ☐ Russian
- ☐ Other:___________

Marital Status
- ☐ Single
- ☐ Single With Partner
- ☐ Domestic Partnership
- ☐ Married
- ☐ Legally Separated

Insurance Information

Do you have medical insurance? ☐ Yes ☐ No If yes, name of insurance carrier:____________________

Family Size and Income

Monthly household income before taxes: $_____________

Number supported by this income (including yourself):________

Special Populations: Please indicate if you meet the criteria for any of the special populations below.

☐ Yes ☐ No **Migrant Worker:** An individual who moves regularly in order to find work.

☐ Yes ☐ No **Disabled:** An individual who has a physical or mental condition that severely limits day-to-day activities.

☐ Yes ☐ No **Substance User:** An individual whose use/abuse of legal and/or illegal substances has affected his/her physical, mental, or social health.

☐ Yes ☐ No **Homeless:** An individual who lacks a regular and adequate nighttime residence (includes individuals residing in transitional housing and those living with friends or relatives for a short period of time).

Marketing Plan

Of the sources below, which ONE was the most important in getting you to contact PPGG for services?

- ☐ Friend or Family
- ☐ PPGG Community Educator
- ☐ PPGG Promotora
- ☐ PPGG Web site
- ☐ Radio
- ☐ School Newspaper
- ☐ Television
- ☐ Yellow Pages
- ☐ Other:_________________

PLANNED PARENTHOOD GOLDEN GATE: CONFIDENTIAL MEDICAL HISTORY

NAME: ______________________________ DATE OF BIRTH: ____________ CLIENT #: __________

FAMILY HISTORY

Have your PARENTS, BROTHERS OR SISTERS ever had:

- ☐ yes ☐ no Heart attack before age 50
- ☐ yes ☐ no High blood pressure
- ☐ yes ☐ no High cholesterol
- ☐ yes ☐ no Sickle cell, Tay Sachs, PKU, or other genetic conditions
- ☐ yes ☐ no Diabetes
- ☐ yes ☐ no Stroke
- ☐ yes ☐ no Cancer (Type:_________)
- Birth defects
- ☐yes ☐no Did you or your mother take DES (a hormone) during pregnancy?
- ☐yes ☐no Are you adopted?

MENSTRUAL HISTORY

(When not taking birth control pills)

Age first period started: ______________

Periods come every ______________ days

They last ______________ days

Pads/tampons used per day: __________

Cramps: None ___ Moderate ___ Severe ___

Bleeding between periods: yes ___ no ___

BIRTH CONTROL HISTORY

If you use birth control, what methods have you used?

- ☐Condoms, Rubbers
- ☐ Depo-Provera
- ☐ Diaphragm/Cervical Cap
- ☐ Foam, Suppositories, Cream, Jelly
- ☐ I.U.D.
- ☐ Lunelle
- ☐ Norplant
- ☐ Nuvaring
- ☐ Patch
- ☐ Pills (*type:* ____________________)
- ☐ Rhythm or Calendar
- ☐ Sponge
- ☐ Tubal Ligation (*Sterilization*)
- ☐ Vaginal Film
- ☐ Withdrawal or Pulling Out
- ☐ None

List any problems with these methods:

____

____

Present method: ______________________

GYNECOLOGICAL HISTORY

Check if you have ever had any of these problems.

Yes	No	Disease of or surgery on:
☐	☐	Breast
☐	☐	Uterus
☐	☐	Cervix
☐	☐	Tubes
☐	☐	Ovaries
☐	☐	Abdomen
☐	☐	Abnormal Pap Smear
☐	☐	Freezing of cervix
☐	☐	Uterine abnormalities
☐	☐	Infertility
☐	☐	Pain with sex
☐	☐	Bleeding after sex
☐	☐	Unusual vaginal bleeding
☐	☐	Frequent vaginal infections
☐	☐	Chlamydia
☐	☐	Gonorrhea
☐	☐	Syphilis
☐	☐	Herpes
☐	☐	Genital warts
☐	☐	Pelvic infection

Date of last pap smear: pap smear: ____________

Was it normal? yes no

All services are confidential, however, in cases of life threatening emergencies and physical or sexual abuse, we may need to make a referral to another agency.

PREGNANCY HISTORY

Number		Date (s)
______	Live births	__________
______	Cesarean	__________
______	Miscarriage	__________
______	Stillbirths	__________
______	Abortions	__________
______	Ectopic (tubal) pregnancies	__________
______	Number of children now living	

Problems with pregnancy, including toxemia and birth defects: ____________________

____

SEXUAL HISTORY

Age at first intercourse: ____ New sexual partner in the last 3 months? Yes no Number of partners in the last 3 months: ___ male ___female

- ☐ yes ☐ no Does your partner(s) have other partners?
- ☐ yes ☐ no Male partner treated for painful urination or discharge?
- ☐ yes ☐ no Do you have any concerns about sex? Transmitted infections?

Have you ever had:

- ☐ yes ☐ no a partner with a history of IV drug use?
- ☐ yes ☐ no a partner with multiple partners?
- ☐ yes ☐ no a bisexual partner?

In the last year:

- ☐ yes ☐ no Have you had vaginal intercourse?
- ☐ yes ☐ no Have you had anal intercourse?
- ☐ yes ☐ no Have you had oral sex?
- ☐ yes ☐ no Do you have any concerns about physical or sexual abuse that you would like to discuss?

GENERAL MEDICAL HISTORY *(Check "Yes" if you have ever had any of these problems)*

Yes	No	
☐	☐	Anemia
☐	☐	Birth defects
☐	☐	Bleeding from rectum
☐	☐	Bleeding or clotting disorder
☐	☐	Blood transfusions/exposure to blood products
☐	☐	Cancer or tumors
☐	☐	Chemical/radiation exposure
☐	☐	Diabetes
☐	☐	Epilepsy or seizures
☐	☐	Eye problems (other than glasses)
☐	☐	Gall bladder problems
☐	☐	Genetic conditions
☐	☐	Heart disease (valve defects, rheumatic fever, murmurs)
☐	☐	High blood pressure
☐	☐	High blood fats (cholesterol, etc.)
☐	☐	Kidney or bladder problems
☐	☐	Lung problems (asthma, chest pain)
☐	☐	Liver problems (hepatitis, mono)
☐	☐	Phlebitis (blood clots in veins)
☐	☐	Sensory problems (numbness)
☐	☐	Severe depression or psychiatric care
☐	☐	Severe or frequent headaches
☐	☐	Stomach or intestinal problems (ulcer, colitis, etc.)
☐	☐	Stroke
☐	☐	Thyroid problems
☐	☐	Tuberculosis (positive skin test? Yes No)
☐	☐	Varicose veins
		Other medical problems: ______________

Explain any hospitalizations or surgeries: ____

Are you allergic to any medicine (penicillin, tetracycline, aspirin), iodine, novocaine or copper? ☐ yes ☐ no Specify: ______________

Have you had 3 day measles (rubella) or immunized for rubella? ☐ yes ☐ no ☐ do not know

Have you been immunized for Hepatitis B? ☐ yes ☐ no; Tetanus? ☐ yes ☐ no; Other: ____________________

HABITS AND LIFESTYLE

1. Do you take prescribed medications, over the counter medications, or street drugs? ☐ yes ☐ no
   If so, please list: ____________________
   If in the past, please list: ____________________
2. If you take drugs, how do you take them (snort, shoot up, skin pop, smoke, pop, etc.)? ____________________
3. Do you drink alcohol? ☐ yes ☐ no Number of drinks per day: __________ per week: __________
4. Do you consider yourself to have (had) a problem with drugs or alcohol? ☐ yes ☐ no
5. Have you ever had a blackout while drunk or high (Have you done things you don't remember doing)? ☐ yes ☐ no
6. Do you smoke cigarettes? ☐ yes ☐ no How many cigarettes a day: __________ per week: __________
7. Have you ever smoked? ☐ yes ☐ no How long: __________ When did you quit: __________
8. Do you exercise? ☐ yes ☐ no What type: ______ How many times per week: ______ How long: ______
9. Do you consider your diet healthy? ☐ yes ☐ no
10. What is your current living situation (parents, friends, squat, street, shelter, foster home, school, etc.)? ____________________
11. Any recent life changes (divorce, moved, death, etc.)? ____________________
12. Has anyone ever touched you in a way that was frightening, painful, or made you feel uncomfortable? ☐ yes ☐ no
13. Is there something you need support with or a referral for? ☐ yes ☐ no If yes: ____________________

SUPPLEMENTAL MALE MEDICAL HISTORY

Have you noticed, or had diagnosed, any of the following:

☐ yes ☐ no Unusual discharge from the penis?
☐ yes ☐ no Skin diseases of the scrotum or penis?
☐ yes ☐ no NGU or NSU?
☐ yes ☐ no Varicocele?
☐ yes ☐ no Hydrocele?
☐ yes ☐ no Other? ____________________

MID-LIFE HISTORY

If you are still having menstrual periods, have you noticed a change in the past year? ☐ yes ☐ no

How? ☐ more days ☐ fewer days
☐ heavier flow ☐ lighter flow
☐ more days between cycles ☐ fewer days between cycles

How many months ago did you notice these changes? ____________________
Do you ever bleed or spot between periods? ☐ yes ☐ no
Have you experienced hot flushes/flashes or night sweats? ☐ yes ☐ no
How long ago did you first notice these symptoms? ____________________
How frequently do you experience these symptoms? ____________________
Are you having any vaginal dryness/irritation or decreased lubrication with intercourse? ☐ yes ☐ no

PERSONAL MEDICAL HISTORY

☐ yes ☐ no Have you had a mammogram? When*:* ____________________
☐ yes ☐ no Any problems with bladder control, leaking urine with coughing, sneezing?
☐ yes ☐ no Any moodiness, depression, irritability?
☐ yes ☐ no Any trouble sleeping?
☐ yes ☐ no Regularly take vitamins? What kind: ____________________
☐ yes ☐ no Regularly take calcium? What kind: ____________________
☐ yes ☐ no Consume any caffeine (chocolate, coffee, tea)? Daily amount: ____________________
☐ yes ☐ no Any exercise regularly? What kind: ____________________
☐ yes ☐ no Smoke? Amount: ____________________

SUPPLEMENTAL MEDICAL HISTORY

Current medications (please list): ____________________
Current medical problems (please list): ____________________

FAMILY HISTORY

Any family member (parents, brothers, sisters, grandparents) had: Relationship

Menopause before age 45 ☐ yes ☐ no ____________________
Fracture of hip ☐ yes ☐ no ____________________
Compression fracture of spine ☐ yes ☐ no ____________________

To the best of my knowledge, I have answered these questions truthfully:

____
Client Signature Date

Reviewed by Staff:

____
Staff Signature Date

____
Staff Signature Date

____
Staff Signature Date

____
Staff Signature Date

HEALTH ACCESS PROGRAMS
FAMILY PACT PROGRAM
CLIENT ELIGIBILITY CERTIFICATION (CEC)

Client identification number

This form is the property of the State of California, Department of Health Services, Office of Family Planning, and cannot be changed or altered.

Please ***print*** answers to all questions. The questions about your family size, income, and health care insurance are to determine if you are eligible for Family PACT Program services.

- Providers must keep a copy of this form in the client's medical record. (See PPBI, Client Eligibility Certification Form Completion Section for code determinations.)
- ***Code areas are for Provider use only.***

Do you currently receive Medi-Cal benefits or services? ☐ Yes ☐ No

Do you have a Medi-Cal Benefits Identification Card (BIC)? ☐ Yes ☐ No

BIC number	Issue date

Do you have health care insurance for family planning services? (Private insurance, Health Maintenance Organization (HMO), Managed Care Plan, Student Health Insurance, etc.) ☐ Yes ☐ No

Do we need to keep your family planning services confidential from your partner, spouse, or parent? How may we contact you if we need to talk to you about something? ☐ Yes ☐ No *Confidentiality* — ***Provider Use Only***—**CODE**

First name	Middle name	Last name	Suffix (Jr., Sr.)

Is your current name the same as your name at birth? If no, print your name at birth below. ☐ Yes ☐ No

First name at birth	Middle name at birth	Last name at birth	Suffix (Jr., Sr.)

Number of live births	County of residence	***Provider Use Only***—**CODE**	Nine-digit ZIP code

Gender	***Provider Use Only***—**CODE**	Social security number	Mother's first name
☐ Male ☐ Female			

Date of birth (mm/dd/yyyy)	Place of birth (county, if California)	***Provider Use Only***—**CODE**	State (if not California)	***Provider Use Only***—**CODE**	Country (if not USA)	***Provider Use Only***—**CODE**
/ /_ _ _ _						

Race/ethnicity

1 ☐ Asian 2 ☐ Black 3 ☐ Filipino 4 ☐ Hispanic
5 ☐ Native American 6 ☐ Pacific Islander 7 ☐ White 0 ☐ Other

Primary Language

1 ☐ Armenian 2 ☐ Cantonese 3 ☐ English 4 ☐ Hmong 5 ☐ Khmer/Cambodian
6 ☐ Korean 7 ☐ Tagalog 8 ☐ Spanish 9 ☐ Vietnamese 0 ☐ Other

This information will be used to see if you are enrolled in any state health program. Information will also be used to monitor health outcomes and for program evaluation purposes. Your name will not be shared. Each individual has the right to review personal information maintained by the provider unless exempt under Article 8 of the Information Practices Act.

Complete eligibility information on reverse side.

Eligibility Determination: Please list all family members (self, spouse, and children) living in your household and supported by the family income. List the source of any earned or unearned income and the amount of income, including income from employment, self-employment, tips, commissions, pensions, social security, child and/or spousal support, ongoing insurance payments, disability, Veterans Affairs, unemployment benefits, etc.

Name	Relationship to You	Age	Source of Income	Gross Monthly Income (Before taxes or deductions.)
	(Self)			
Family size:			Total family income	$

I declare under penalty of perjury that the information I have given on this form is true, correct, and complete. I understand that the giving of false information may make me ineligible for this program.

Signature (or mark) of applicant	Date	Signature of witness to mark or interpreter	Date

FOR PROVIDER USE ONLY

Provider certification: ☐ Eligible for Family PACT Program
☐ Ineligible for Family PACT Program (Give applicant Fair Hearing Rights.)

Medi-Cal client eligible for Family PACT verified: ☐ Limited scope ☐ Unmet share-of-cost

Based upon the information provided by the applicant and according to state and federal requirements, I certify that the applicant identified on this Client Eligibility Certification is eligible to receive family planning services under the Family PACT Program. If ineligible, the client has received a copy of this form which includes the Fair Hearing Rights.

Print name	Signature	Date

Annual Certification: If client is decertified (no longer eligible)	Date	Reason code (see Provider Manual)

Fair Hearing Rights

Any applicant for, or recipient of, services under the Family PACT Program has a right to a hearing conducted by the Department of Health Services regarding eligibility or receipt of services. An applicant or recipient does not have a right to contest changes made to the eligibility standards or benefits of the Family PACT Program.

First level review: If you wish to appeal either your denial of eligibility or receipt of services, please send your name, telephone number, address, and reason why you are requesting a review to the **First Level Review address** below. A request for a first level review must be postmarked within 20 working days of the denial of eligibility or services. The Office of Family Planning may request additional information by telephone or in writing from the provider or the applicant before issuing a decision.

Formal hearing: You may appeal the decision of the first level review within five working days of your receipt of the decision of the first level review by sending your name, telephone number, address, and reason for the appeal to the **Formal Hearing address** below. At the hearing, you may be represented by a friend, relative, lawyer, or other person of your choice. A representative of the provider will be present to explain the reasons for denying eligibility. If you want an interpreter provided at the hearing, please specify the language in your letter requesting a hearing.

First Level Review

Office of Family Planning
Department of Health Services
714 P Street, Room 440
P.O. Box 942732
Sacramento, CA 94234-7320

Formal Hearing

Office of Administrative Hearings and Appeals
Department of Health Services
714 P Street, Room 1216
P.O. Box 942732
Sacramento, CA 94234-7320