

PATIENT CONTACT AND STATISTICAL INFO

Full Name: _____

Previous/Maiden Name: _____

Social Security #: _____ - _____ - _____

Date of Birth: _____ / _____ / _____

PPSFL must have a mailing address where we can contact you. If we cannot send mail to your physical home address, please provide a mailing address here. (Our name **will not** appear on the envelope.)

In Care of: _____

Street: _____

City: _____

State: _____ Zip: _____

Home Address:

Street: _____

City: _____

State: _____ Zip: _____ County: _____

May we send mail to this address? (Our name **will not** appear on the envelope.) Yes No

Please be aware that we cannot make confidential calls to phones with caller I.D.

Preferred Daytime Phone: Home Work Cell Other
(____) _____ - _____ Caller ID? Yes No

If we call and you do not answer the phone: (Check one)

- OK to say "Planned Parenthood is calling".
- Prefer we say "This is your Doctor's Office calling".
- Use the code name "Casey" or _____

Preferred Evening Phone: Home Work Cell Other
(____) _____ - _____ Caller ID? Yes No

If we call and you do not answer the phone: (Check one)

- OK to say "Planned Parenthood is calling".
- Prefer we say "This is your Doctor's Office calling".
- Use the code name "Casey" or _____
- It is okay to contact me via e-mail.

E-Mail Address: _____

Patient Label: _____

In case of an emergency, please provide information about someone we may contact who will **ALWAYS** know how to reach you. Minors must provide the name of an adult (if not a parent, then another relative or adult friend is sufficient).

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ - _____

Relationship to you: _____

*I understand Planned Parenthood is required to contact me regarding abnormal test results. Confidentiality will be maintained as much as possible, but If Planned Parenthood cannot contact me via the information I have provided, I understand **confidentiality may need to be broken.***

X _____ / _____ / _____
Patient Signature Today's Date

STATISTICAL INFORMATION REQUIRED BY THE STATE OF NEW YORK:

Sex: Female Male Other

Race: Please check all that apply:

- American Indian Alaskan Native Asian
- Black/African American White Other
- Pacific Islander/Hawaiian Native

Are you Hispanic? Yes No

Bilingual staff/ interpreter needed? Yes No

How did you find out about PP's services: Friend Relative
 Physician Phonebook Internet PP Educator Other

Are you a student? No Yes: _____ Full time _____ Part time

What is the highest grade of school you have **completed**? (Circle one)

6 7 8 9 10 11 12 13 14 15 16 17+

If you are a college/graduate student, which school do you attend?

Are you employed? No Yes: _____ Full time _____ Part time

Employed by: _____

Address: _____

Marital Status: Single Separated Living with Partner
 Married Divorced Widowed

Check this box if you use another clinic/provider as your **main** source of healthcare.

FEMALE PATIENTS ONLY: # of living children: _____ # of births: _____

of times pregnant: _____ Date last pregnancy ended: _____

For contraceptive patients:

The person(s) listed below will not have access to your medical records. I give permission for the following person(s) to pick up my **supplies**:

Name	Relationship to you
_____	_____
_____	_____
_____	_____
_____ / _____ / _____	_____ / _____ / _____
Patient Signature	Today's Date