

Social Data

Pt # _____

Please remember that all of our services are confidential.

Name _____ Birth Date _____ SSN _____

Address _____ City _____ State _____ Zip _____

If abnormal results are received, we are obligated to contact you. If we are filing for insurance, you must mark "Yes" for mail.

- Yes, I can receive Planned Parenthood mail.
- No, please send mail in an unmarked envelope.

Home Ph # _____ Work Ph # _____ Cell Ph # _____

Call my home phone with a message to call Planned Parenthood. Yes No

Call my work phone with a message to call Planned Parenthood. Yes No

Call my cell phone with a message to call Planned Parenthood. Yes No

Call home with message to call _____

Race (select one or more):

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

Ethnicity:

- Hispanic/Latino
- Non-Hispanic/Non-Latino

Marital Status:

- Single Married Widow
- Divorced Separated Live w/ partner

Do you identify as:

- Male Female

In case of emergency, please name a relative 18 years of age or older who we can contact.

Name _____ Phone _____ Relationship _____

Does he/she know you are a patient at Planned Parenthood? Yes No

Alternative Supply Pick-Up Consent

If you are unable to personally come to the clinic to pick up supplies, it is permissible for someone else to do so for you.

- If you are having problems with your method or are late starting your method, you must report to the clinic yourself.
- Your alternate may pick up only one month of supplies.

I understand these conditions and I designate one person other than myself to pick up supplies.

That person is _____

Signed _____ Date _____

-----**For office use only, do not write below this line.**-----

Date _____ Method _____

Patient Type _____ Staff _____

Pay Type _____

Language Assistance Needed? Yes No

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Primary Insurance Information

Insurance Carrier _____ Policy # _____

Cardholders Name _____ SSN _____

Cardholders Address _____ DOB _____

Cardholders Place of Employment _____

Secondary Insurance Information

Insurance Carrier _____ Policy # _____

Cardholders Name _____ SSN _____

Cardholders Address _____ DOB _____

Cardholders Place of Employment _____

Insurance Authorization

I authorize the release of any medical or other information necessary to process insurance claims on my behalf. I authorize payment of medical benefits to PPSI for services provided to me. I understand that I am financially responsible for all charges, co-payments or deductibles that my insurance company does not cover. I understand that I will be billed by PPSI and I agree to pay any balance or arrange a payment plan.

Signature _____ Date _____

Insurance Questionnaire/Survey

Please answer the following questions to the best of your ability. Due to confidentiality issues we understand that you may choose to not utilize insurance coverage that may be available to you. The answers to the questions listed below will not affect if/how your insurance is billed; this is for informational purposes only.

Check all that apply:

Yes No

- Medicaid (*Examples: Title XIX, Iowa Health Solutions-Medicaid*)
- Military health insurance (*Examples: TRICARE, CHAMPVA*)
- Other public health insurance (*Examples: Care For Yourself, Medicare, Iowa Health Solutions-HAWK-I*)
- Private health insurance (*Examples: Blue Cross / Blue Shield, United Healthcare, Prudential, etc.*)
- Uninsured (*Title XX or no insurance coverage at all*)

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