Planned Parenthood®
Southeastern Pennsylvania

REQUEST FOR MEDICAL SERVICES AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

DATE:______________________________ PATIENT #:________________________________

NAME OF PATIENT:____

DATE OF BIRTH:_____________________ TELEPHONE #: ____________________________

Before you give your consent, be sure you understand the information given below. If you have any questions, we will be happy to talk about them with you. You may ask for a copy of this form.

I understand that I have the right to receive free language interpreter services. I understand that I must tell the staff if these services will be helpful to my understanding of the written or spoken information given during my health care visits.

I have been given information about the test(s), treatment(s), procedure(s), contraceptive method(s), to be provided, including the benefits, risks, possible problems/complications and alternate choices. I understand that I should ask questions about anything I do not understand. I understand that a clinician is available to answer any questions I may have.

No guarantee has been given to me as to the results that may be obtained from any services I receive. I know that it is my choice whether or not to have services. I know that at any time, I can change my mind about receiving medical services at Planned Parenthood.

I understand that if tests for certain sexually transmitted infections are positive, reporting of positive results to public health agencies is required by law. I understand that a new Pennsylvania law requires PPSP to give me written notification if a serious event compromising patient safety occurs under specific circumstances and that this notification will be sent to the mailing address listed on my contact sheet.

I will be given referrals for further diagnosis or treatment if necessary. I understand that if referral is needed, I will assume responsibility for obtaining and paying for this care. I have been told how to get care in case of an emergency.

I understand that confidentiality will be maintained as described in Planned Parenthood Southeastern Pennsylvania's *Notice of Health Information Privacy Practices*. I consent to the use and disclosure of my health information as described in *Notice of Health Information Privacy Practices*.

I hereby voluntarily request that a person authorized by Planned Parenthood provide appropriate evaluation, testing, and treatment (including a birth control drug or device, or HIV antibody test, if I request it).

I hereby acknowledge receipt of Planned Parenthood Southeastern Pennsylvania's Notice of Health Information Privacy Practices.

Signature of Patient ____

Date ____

I witness the fact that the patient received the above mentioned information and said s/he read and understood same and had the opportunity to ask questions.

Signature of Witness ____

Date ____

N0001/0110

Planned Parenthood®
Southeastern Pennsylvania

Contact /Personal Information

Patient Number ______________________ Today's Date ______________

Name ______________________ Nickname ______________
First Last (optional)

Address ______________ / ______________ / ______ / ______ /
Street Apt# City State Zip

Is it O.K. for us to contact you by mail at above address? [ ]Yes [ ]No
If yes, can we use a Planned Parenthood envelope? [ ]Yes [ ]No
Address for mail, if different from the one above:

______ / ______________ / ______________ / ______ / ______ /
c/o Name Street Apt# City State Zip

Can we use a Planned Parenthood envelope at this address? [ ]Yes [ ]No

Your Telephone numbers
Phone 1 (______) ______________________(home) (work) (cell) Best time to call? _______
May we say "Planned Parenthood" to anyone who answers at this number? [ ] yes [ ] no; Code name:_________

Phone 2 (______) ______________________ (home) (work) (cell) Best time to call? ________
May we say "Planned Parenthood" to anyone who answers at this number? [ ] yes [ ] no; Code name: _____________

Marital status: [ ] Married [ ] Not Married

Social Security Number __ __ __ - __ __ - __ __ __ __ [ ] Female [ ] Male

Birth Date __ __ - __ __ - __ __ __ __ Age ________ **Staff Use Only:** ID Verified: [ ] yes [ ] no

Referred By: How were you referred to us?

[ ] Other Planned Parenthood Site [ ] Drove/walked by Center [ ] Family/Friend [ ] Internet
[ ] Newspaper Ad [ ] CHOICE Hotline [ ] Doctor [ ] Yellow Pages
[ ] Program done by PPSP [ ] School/College [ ] Other__________________

Sometimes Planned Parenthood likes to contact patients for your suggestions or to give you information. May we:
[ ] Call to get your opinion over the telephone about your patient care experiences?
[ ] Send you information about Planned Parenthood from any of its departments in a Planned Parenthood envelope?
[ ] Please do not contact me for these purposes.

Who can we contact if unable to reach you or in case of emergency? (**This information is legally necessary**):

Name ______________________
First Last

Address ____
Bldg # Street Apt# City State Zip

Phone Number (_____) ____________
Does this person know you are here [ ] Yes [ ] No Relationship______________
Should we (1) use a Planned Parenthood envelope or (2) plain envelope (circle the appropriate number)

Is it (1) OK to say Planned Parenthood to anyone who answers or (2) should we only use Planned Parenthood when speaking to the contact person? (Please circle appropriate number)

What is the name of your family doctor?

Patient Name____ Patient Number____________________

The information below is for statistical use only. No person will be excluded from services at Planned Parenthood Southeastern Pennsylvania based on duration of residency, citizenship, national origin, race, sexual orientation, marital status, religion, color, sex, method of referral, or contraceptive preference. With Census 2000, the Federal government introduced the option for choosing multiple races. Please choose from the lists below.

What county do you live in:
[ ] Chester County, PA [ ] Delaware County, PA [ ] Montgomery County, PA [ ] Philadelphia County, PA

[ ] Other Pennsylvania County ________________ (which county?) [ ] Other State______________ (which state?)

Race/ Ethnicity
[ ] (04) Asian
[ ] (01) Black/African-American
[ ] (03) Native American/Alaskan Native
[ ] (07) Pacific Islander/Native Hawaiian
[ ] (02) White
[ ] (08) Asian + Black
[ ] (09) Asian + Native American/Alaskan Native
[ ] (10) Asian + Pacific Islander/Native Hawaiian
[ ] (11) Asian + White
[ ] (12) Black + Native American/Alaskan Native
[ ] (13) Black + Pacific Islander/Native Hawaiian
[ ] (14) Black + White
[ ] (15) Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (16) White + Native American/Alaskan Native
[ ] (17) White + Pacific Islander/Native Hawaiian
[ ] (18) Asian + Black + Native American/Alaskan Native
[ ] (19) Asian + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (20) Asian + White + Native American/Alaskan Native
[ ] (21) Asian + Black + Pacific Islander/Native Hawaiian
[ ] (22) Asian + Black + White
[ ] (23) Asian + White + Pacific Islander/Native Hawaiian
[ ] (24) Black + White + Native American/Alaskan Native
[ ] (25) Black + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (26) Black + White + Pacific Islander/Native Hawaiian
[ ] (27) White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (28) Asian + Black + White + Pacific Islander/Native Hawaiian
[ ] (29) Asian + Black + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (30) Asian + Black + White + Native American/Alaskan Native
[ ] (31) Asian + White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (32) Black + White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (33) Asian + Black+ White + Native American/Alaskan Native + Pacific Islander/Native Hawaiian
[ ] (05) Other or Unknown

Are you of Hispanic origin? [ ] yes [ ] no

What is your primary language? (if not English)

[ ] Albanian	[ ] Chinese	[ ] Hindi	[ ] Portuguese	[ ] Ukranian
[ ] Arabic	[ ] Creole	[ ] Ibo	[ ] Russian	[ ] Urdu
[ ] Bosnian/Croation	[ ] Ethiopian	[ ] Laotian	[ ] Spanish	[ ] Vietnamese
[ ] Cambodian	[ ] French	[ ] Mandarin	[ ] Tagalog	[ ] American Sign Language
[ ] Cantonese	[ ] Greek	[ ] Polish	[ ] Turkish	

[ ] Other_______________________ (which language?)

Are you a student: [ ] yes [ ] no

What is the highest grade you have completed (do not include the one you are in now)? ______
If you are in high school, middle school, junior high or elementary school, what is the name of your school?
____

Current Birth Control Method:
[ ] Birth Control Pills
[ ] Cervical Cap
[ ] Condom - female
[ ] Condom - male
[ ] Condom and Spermicide
[ ] Depo-Provera
[ ] Diaphragm
[ ] Implanon
[ ] IUD
[ ] Natural Family Planning / Fertility Awareness
[ ] NuvaRing
[ ] Patch (Ortho Evra)
[ ] Other
[ ] Spermicide
[ ] Sponge
[ ] Sterilization
[ ] None – pregnant
[ ] None – seeking pregnancy
[ ] None – not currently sexually active
[ ] None – not at risk of becoming pregnant
[ ] None – not interested or undecided

Planned Parenthood®
Southeastern Pennsylvania

Financial Assessment and Responsibility

Patient Name: ______________________________ Patient Number: ______________________ Date: ________________

The fees patients pay at Planned Parenthood are vital to allowing us to continue to provide services. However, there are a number of state, federal and private programs that allow us to discount the part of your services for which you are responsible. We ask the following questions to determine if you qualify for any discounts.

The financial information you provide will not result in denial of services.

If you choose not to answer the questions about your household income, we will not discount your services and you will be responsible for paying the full, non-discounted price today.

	Yes	No		Yes	No
I am female			I am pregnant OR have had my tubes tied		
I am between the ages of 18 and 44			I have private medical insurance* that covers contraceptives.		
I am a US Citizen or am a Permanent Resident with a Green Card			Submitting an insurance claim would violate my confidentiality or cause me harm		
I have a Social Security Number			I currently receive Medical Assistance OR SelectPlan for Women benefits		
I am a resident of Pennsylvania			I received Medical Assistance in the past 4 months		

I am employed. ☐ Yes ☐ No If Yes: I work _________________ hours per week and earn $_____________ per hour.
2: I work _________________ hours per week and earn $_____________ per hour.
3: I work _________________ hours per week and earn $_____________ per hour.

I am legally married and live with my spouse. ☐ Yes ☐ No OR I live with my partner ☐ Yes ☐ No
His/her salary – ***before taxes*** – is: $ _______________ ☐ weekly ☐ every two weeks ☐ monthly ☐ annually

I have children: ☐ Yes ☐ No. If Yes: (#) ________ children and __________ live with me.
I have financially dependent children / step-children. ☐ Yes ☐ No
One or more of them ☐ is working ☐ pays rent. If yes to either or both, total is $____________ per month.

I pay for child / adult dependent care so that I can work. ☐ Yes ☐ No
If Yes: The total I pay is $ __________ per month.

I have the following other sources of income: [check all that apply]
☐ child support / alimony $ __________ per month ☐ unemployment $ __________ per month
☐ worker's comp / disability $ __________ per month ☐ my children's income $ __________ per month

I am supported by the following. Check and complete if applicable.
☐ Parent(s) or legal guardian(s) earns $ __________ ☐ hourly ☐ weekly ☐ every two weeks ☐ monthly ☐ annually.
☐ Other (e.g. relative / roommate), please list: ____________________________________ earns $ ___________________
....☐ hourly ☐ weekly ☐ every two weeks ☐ monthly ☐ annually.

Patient Name: ______________________________ Patient Number: ______________________ Date: ________________

ALL PATIENTS, PLEASE CHECK EACH BOX AND SIGN WHERE INDICATED:

☐ The information I have provided here is true and complete, to the best of my knowledge.

☐ I agree to provide documentation of any information I've reported here, if required.

☐ I may be assessed at each visit; my fee category may change if my circumstances or the fee scale changes.

☐ I understand PPSP will attempt to collect any unpaid balances.

Signature	Date

FOR PATIENTS WITH COMMERCIAL, MA, OR SP HEALTH INSURANCE ONLY. PLEASE READ EACH ITEM CAREFULLY:

☐ I am responsible for paying for any services not covered by my insurance, including co-pays, deductibles, uncovered services, or those provided when my coverage was not in effect. These fees may be charged by PPSP and/or independent labs.

☐ I authorize direct payment on my behalf from my insurance carrier(s) to PPSP.

☐ I authorize PPSP to submit my insurance information to an independent laboratory for any testing that I receive.

☐ Correspondence from my insurance company may be sent to the address of record for the policy, and that it may indicate what services were provided.

- Are you under another person's insurance? If so, please provide their full name:______________________________

OR:

☐ **DO NOT USE MY INSURANCE.** Using my insurance would breach my confidentiality, and I prefer to pay PPSP and/or an independent laboratory directly for all services I receive.

Signature	Date

►►►►► STAFF USE ONLY ◄◄◄◄◄

Date	Weekly Inc-Hhold Size (ex. 425-02)	Fee Category (ex. A-B or T-D)	SP Status (ex. Applied, Active, Denied, Ineligible)	Comments	Staff Initials

Reason for no SP app: ☐ Age ☐ Inc ☐ Ins ☐ MA ☐ C/I ☐ Res ☐ Pr/St ☐ Ref ☐ ID

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MEDICAL HISTORY - GYN

Patient Name:____________________ **Age:**______ **Medical Record #:**____________ **Date:**____________

☐ **New Patient** ☐ **Established Patient**

SUBJECTIVE:

CHIEF COMPLAINT / Why are you here today? ☐ Routine GYN Exam ☐ Problem ☐ Other __________________
How do you identify? ☐ Female ☐ FTM ☐ Other __________

No	Yes	
☐	☐	Are you receiving medical care with another health provider? Reason for visit(s) __________
☐	☐	Are you allergic to any medications, metals, foods, anesthesia or other products? List: __________
☐	☐	Are you currently taking any medications (including herbal remedies and vitamins)? List: __________

FAMILY HISTORY

No	Yes	
☐	☐	I am adopted; my birth history is unknown.
☐	☐	Did your mother take DES while she was pregnant with you? (if you were born before 1971)

Does your Mother (M), Father (F), Sister (S), Brother (B), Grandmother (GM) or Grandfather (GF) have any of the following?

No	Yes		Who
☐	☐	High cholesterol	__________
☐	☐	High blood pressure	__________
☐	☐	Heart attack before age 50	__________
☐	☐	Stroke / Blood clots	__________

No	Yes		Who
☐	☐	Diabetes	__________
☐	☐	Breast disease	__________
☐	☐	Cancer	__________
☐	☐	Genetic disorder(s)	__________

Circle: Father is living / deceased. Cause of death __________ Mother is living / deceased. Cause of death __________

PERSONAL HISTORY – Have YOU been diagnosed or treated for any of the following:

	No	Yes	
1.	☐	☐	Cancer
2.	☐	☐	Genetic condition
3.	☐	☐	High cholesterol / triglycerides
4.	☐	☐	High blood pressure
5.	☐	☐	Heart disease / Murmur / MVP
6.	☐	☐	Stroke / Blood clots
7.	☐	☐	Anemia
8.	☐	☐	Blood clotting disorder
9.	☐	☐	Sickle cell anemia / trait
10.	☐	☐	Breast problems / Surgery
11.	☐	☐	Asthma
12.	☐	☐	Lung problems / Tuberculosis
13.	☐	☐	Kidney / Bladder / Urinary Tract infection or problems
14.	☐	☐	Recurrent vaginal infections
15.	☐	☐	Pelvic infection / PID
16.	☐	☐	Abnormal Pap smear
17.	☐	☐	Cervical cryo, LEEP, Laser or Cone biopsy
18.	☐	☐	Diabetes
19.	☐	☐	Thyroid disease
20.	☐	☐	Liver disease / Hepatitis / Mono
21.	☐	☐	Gall bladder disease
22.	☐	☐	Past surgery(s)
23.	☐	☐	Past hospitalization(s)
24.	☐	☐	Vaccination for Hepatitis B
25.	☐	☐	Vaccination for Rubella / MMR

REVIEW OF SYSTEMS

	No	Yes	
Constitutional:			
26.	☐	☐	Generally healthy
Cardiovascular:			
27.	☐	☐	Swelling / Fluid retention in hands or feet

REVIEW OF SYSTEMS – CONTINUED

	No	Yes	
Hematological:			
28.	☐	☐	Easily bruised
29.	☐	☐	Varicose veins
Neurological:			
30.	☐	☐	Headaches (frequent / severe) / Migraine
31.	☐	☐	Numbness / Sensory loss
32.	☐	☐	Seizures
Respiratory / Chest:			
33.	☐	☐	Breast lump / discharge
34.	☐	☐	Shortness of breath
Eyes:			
35.	☐	☐	Blurred / Double vision (Not corrected by glasses or contacts)
Gastrointestinal:			
36.	☐	☐	Abdominal pain
37.	☐	☐	Bowel pain / Constipation / Diarrhea
38.	☐	☐	Rectal bleeding / Pain
Genitourinary:			
39.	☐	☐	Vaginal discharge, itching or burning
40.	☐	☐	Frequency or burning with urination
41.	☐	☐	Pelvic pain
ENT:			
42.	☐	☐	Ulcers / Sores in your mouth
Psychological:			
43.	☐	☐	Anxiety
44.	☐	☐	Depression
45.	☐	☐	Would you like a mental health referral today?
Skin:			
46.	☐	☐	Rash or itching

Patient Name:____ Age:_______ Medical Record #:_________________ Date:___________________

HEALTH HABITS / SOCIAL HISTORY

No Yes

☐ ☐ Douches
☐ ☐ Self breast exams

☐ ☐ Smokes: _______ cigarettes per day.
☐ ☐ Alcohol intake: ________ drinks per week.
☐ ☐ Drug use: daily / weekly / monthly. Type __________________

☐ ☐ Alcohol and/or drugs cause problems in your life?
☐ ☐ Others are concerned with your alcohol / drug habits?
☐ ☐ Afraid of your partner(s) / others?
☐ ☐ Parent(s) or guardian is aware of your visit today?
(Only answer if under age 18.)

MENSTRUAL HISTORY

Age when period started: ________

Periods are: ☐ Regular ☐ Irregular ☐ Painful
Flow is: ☐ Light ☐ Moderate ☐ Heavy

Periods come every __________ days.

Bleeding lasts ___________ days.

When was the 1st **day** of your last period? ____________________

No Yes

☐ ☐ Was your last period normal?
☐ ☐ Do you think you might be pregnant?
☐ ☐ Do you ever miss periods?
☐ ☐ Do you ever have bleeding between periods?

SEXUAL HISTORY

Age at first intercourse: ______
# of sexual partners in last 30 days: ______
# of sexual partners in lifetime: ______
Partner(s) – Check all that apply: ☐ Male ☐ Female ☐ Transgender ☐ Intersex
Kind of sex: (please indicate all that apply:
☐ Vaginal (Giver / Receiver)
☐ Anal (Giver / Receiver) ☐ Oral (Giver / Receiver)
Do you have pain or bleeding with sex? ☐ No ☐ Yes
Have you ever been forced to have sex? ☐ No ☐ Yes
Have you ever exchanged sex for money or something else you wanted? ☐ No ☐ Yes
Do you consistently use condoms/dental dams for safer sex? ☐ No ☐ Yes
Do you plan children in the future? ☐ No ☐ Yes ☐ Undecided
Planning a pregnancy within the next year? ☐ No ☐ Yes ☐ Undecided

Have you ever had the following?

No Yes

☐ ☐ Chlamydia Date last treated: ____________________
☐ ☐ Gonorrhea Date last treated: ____________________
☐ ☐ Herpes Date last treated: ____________________
☐ ☐ HPV/warts Date last treated: ____________________
☐ ☐ PID Date last treated: ____________________
☐ ☐ HIV Date last treated: ____________________
☐ ☐ Syphilis Date last treated: ____________________
☐ ☐ Trichomonas Date last treated: ____________________

☐ ☐ Currently experiencing itching, burning or unusual discharge?
☐ ☐ Did you douche, use a tampon, have bleeding or sex in the last 3 days?

CONTRACEPTIVE HISTORY

Current method of birth control: ___________________________________

How long have you used this method? _____________________________

What other methods of birth control have you used?

☐ Pills ________________ ☐ Diaphragm ☐ Rhythm/Natural
☐ Depo Provera ☐ Cervical Cap ☐ Withdrawal
☐ Lunelle ☐ Male condoms ☐ Abstinence
☐ Evra Patch ☐ Female condoms ☐ Tubal sterilization
☐ Nuva Ring ☐ Spermacide ☐ Vasectomy
☐ IUD ________________ ☐ Norplant ☐ Implanon

What method, if any, do you want today? __________________________

PREGNANCY HISTORY

☐ Never Pregnant

Age at first pregnancy (at time of conception): _______

# of live births _______ Date(s) ______________________
# of C-sections _______ Date(s) ______________________
# of premature births _______ Date(s) ______________________
# of miscarriages _______ Date(s) ______________________
# of still births _______ Date(s) ______________________
# of abortions _______ Date(s) ______________________
# of ectopics _______ Date(s) ______________________

I would like the following STI screening today:

☐ Chlamydia
☐ Gonorrhea
☐ HIV
☐ Syphilis

I would like information on the following:

Given (Staff Initials)

☐ Birth Control Method(s) __________________ __________
☐ Emergency Hormonal Contraception __________
☐ Preconception __________
☐ Perimenopause __________
☐ Smoking Cessation __________

Patient Signature: ____ **Date:** ________________________

Comments:

☐ STI Risk Assessment done.
☐ Safer sex and condom use reviewed.
☐ ECP discussed / Fact Sheet N0051 given.
☐ HIV pretest counseling done.
☐ Other ________________________.
☐ Pt. urged to discuss visit with parent or guardian.

Interviewer Signature: ____ **Date:** ________________________

Clinician Signature: ____ **Date:** ________________________

Planned Parenthood®
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Additional History for Women 40 and Over

Patient Name:______________________________ Medical Record #:_______________ Date:____________

Family History

No Yes Unsure

☐ ☐ ☐ Age mother and/or sisters went through menopause
☐ ☐ ☐ Osteoporosis

Personal History
Have you ever had or do you have:

No Yes Unsure

☐ ☐ ☐ Difficulty holding urine____________________
☐ ☐ ☐ Hot flashes____________________
☐ ☐ ☐ Night sweats____________________
☐ ☐ ☐ Depression/mood swings____________________
☐ ☐ ☐ Anxiety____________________
☐ ☐ ☐ Heart palpitations____________________
☐ ☐ ☐ Sleeplessness____________________
☐ ☐ ☐ Dryness of the vagina____________________
☐ ☐ ☐ Change in sexual desire____________________
☐ ☐ ☐ Pain or difficulty with urination____________________
☐ ☐ ☐ Change in bowel habits including bloody or tarry stools____________________
☐ ☐ ☐ Osteoporosis or broken bones after age 35____________________
☐ ☐ ☐ Mammogram: Date of last ______, result____________________
☐ ☐ ☐ Other problems____________________

Notes

Staff Signature:____