

Implementation 09/07/10

CONTACT

Date: _____

Last/ First Name: _____ _____ Chart#: _____ D.O.B.: _____
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We will only contact you regarding your care; information will not be sold or used for solicitation purposes

Last Name: _____ First Name: _____

Address: _____ City _____ State _____ Zip _____

County: _____ Do you prefer: ___ "Planned Parenthood" envelope ___ Plain Envelope

Telephone: (1)(_____) _____ (2) (_____) _____

Is it OK to leave a message at these numbers? Yes ___ No ___ "Doctor's Office" only ___

May we send you a text message? Yes ___ No ___

SSN: _____ - _____ - _____ DOB: _____ / _____ / _____

Person to contact in an emergency: _____ Phone: (_____) _____

Please circle one:

SEX: Female Male

RACE: American Indian / Alaskan Native

Asian / Pacific Islander

Black

Eskimo or Aleut

Multiracial

Other

Unknown

White

ETHNICITY:

Hispanic/Latino Non-Hispanic

HOW DID YOU HEAR ABOUT US?

- | | | |
|--|--|--|
| <input type="checkbox"/> Billboard | <input type="checkbox"/> Health Fair | <input type="checkbox"/> PP Sex Educator/Teacher |
| <input type="checkbox"/> Coupon | <input type="checkbox"/> Radio | <input type="checkbox"/> TV |
| <input type="checkbox"/> Doctor's Office | <input type="checkbox"/> Magazine | <input type="checkbox"/> Yellow Pages |
| <input type="checkbox"/> Facebook | <input type="checkbox"/> Myspace | <input type="checkbox"/> Yellow Pages Online |
| <input type="checkbox"/> Family | <input type="checkbox"/> Newspaper | <input type="checkbox"/> Other |
| <input type="checkbox"/> Free EC Day | <input type="checkbox"/> Other funding | |
| <input type="checkbox"/> Friend | <input type="checkbox"/> PP Website | |

What type of Birth Control do you use now?

- | | |
|--|---|
| <input type="checkbox"/> Abstinence | <input type="checkbox"/> Nuva Ring |
| <input type="checkbox"/> Cap / Diaphragm | <input type="checkbox"/> Other (Withdrawal) |
| <input type="checkbox"/> Condoms | <input type="checkbox"/> Patch (Ortho Evra) |
| <input type="checkbox"/> Depo (Shot) | <input type="checkbox"/> Pills (Oral) |
| <input type="checkbox"/> Implanon | <input type="checkbox"/> Sponge |
| <input type="checkbox"/> IUD | <input type="checkbox"/> Sterilization (Tubal or Vasectomy) |
| <input type="checkbox"/> Norplant | <input type="checkbox"/> No Method |

PLANNED PARENTHOOD STAFF USE:

Patient instructed about contact requirements and verbalizes understanding: YES NO

REVIEWED BY _____ DATE _____

REVIEWED BY _____ DATE _____

REVIEWED BY _____ DATE _____