

**PLANNED PARENTHOOD CLIENT DATA TITLE X** (Please print)

Name \_\_\_\_\_ Date \_\_\_\_\_  
( Last ) ( First ) ( M I )

Other names you have used in the past (maiden, nicknames, etc) : Last names: \_\_\_\_\_  
First names: \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  Female  Male

**A MAILING ADDRESS AND TELEPHONE NUMBER ARE REQUIRED IN THE  
EVENT WE NEED TO CONTACT YOU FOR BILLING OR LAB RESULTS**

**MAILING/BILLING ADDRESS** \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Address (if different than above) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Check box if plain envelope is preferred when mail is sent

**WHERE DO YOU PREFER TO BE CALLED AND HOW SHALL WE IDENTIFY OURSELVES WHEN WE CALL?**

First Phone Number \_\_\_\_\_  Planned Parenthood  Doctor's Office  Code Name (Ask Front Desk)

Second Phone Number \_\_\_\_\_  Planned Parenthood  Doctor's Office  Code Name (Ask Front Desk)

In case of emergency, who should we contact? \_\_\_\_\_ Phone Number \_\_\_\_\_

If we call your emergency contact how shall we identify ourselves when we call?

Planned Parenthood  Doctor's Office  Code Name (Ask Front Desk)

**What is your Race? (MARK 1)**  White  Asian  Multiracial  Pacific Islander  
 African American/Black  Native American  Other  Unknown

**Are you Hispanic?**  Yes  No

Occupation/Job: \_\_\_\_\_  Married  Unmarried

**Education:** Indicate a **NUMBER** for the HIGHEST grade **COMPLETED**

(**Example:** you are currently in 11<sup>th</sup> grade-highest grade completed would be 10

None  Elementary/Secondary (1-12) \_\_\_\_\_  College (1-4, 5+) \_\_\_\_\_

**What is your monthly income (before taxes) ? \_\_\_\_\_ How many are supported by this income? \_\_\_\_\_**

**Do you have Oregon Health Plan, also known as Medicaid, welfare, OMAP/DMAP?**

Yes  No

**Please show your insurance card(s) or provide required billing information  
before services are rendered.**

\*\*\*\*\*STAFF USE ONLY\*\*\*\*\*

GMI \_\_\_\_\_  FPEP \_\_\_\_\_  OHP # \_\_\_\_\_ Fee Level: \_\_\_\_\_

**Updated Contact Information:**

**Date:** \_\_\_\_\_  Mailing - Address: \_\_\_\_\_

Home - Address: \_\_\_\_\_

Plain envelope is preferred when mail is sent

Phone: \_\_\_\_\_ **ID:**  PP  Doctor's Office  Code Name

Revised 12/20/11

**STATEMENT OF FINANCIAL RESPONSIBILITY**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

I authorize any insurance benefits to be paid directly to Planned Parenthood of Southwestern Oregon (PPSO) and authorize PPSO or my insurance carrier to release any information required for processing a claim. I understand that if my insurance does not cover any/all services and supplies, or they determine a service/supply to be non-covered, and there are no additional payers, that I will be billed for the balance and that I am ultimately responsible for payment of any charges that I incur. I realize that it is my responsibility to know my insurance coverage and benefits. I understand that my account may be forwarded to a collection agency if I do not pay an outstanding balance.

If covered by Oregon Medicaid programs such as the Oregon Health Plan (OHP) or Oregon Contraceptive Care (CCare), I authorize PPSO to bill any existing private health insurance before billing OHP/CCare unless I have specifically requested, for reasons of confidentiality, that private insurance not be billed.

By signing below, I acknowledge financial responsibility for payment of all services/supplies provided by PPSO, and agree to pay the entire amount due after payment has been made by my insurance carrier.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

A copy of this form is available upon request.