

PLANNED PARENTHOOD CLIENT DATA (Please print)

Name _____ Date _____
(Last) (First) (M I)

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

Address _____

(City) (State) (Zip Code)

Phone Contact: Home _____ Work _____ Cell/Message _____

If we call, may we identify it is Planned Parenthood calling? **Home?** YES NO **Work?** YES NO **Cell?** YES NO

Can we send mail related to your medical care in an envelope that says Planned Parenthood? YES NO

Date of Birth _____ Age _____ Female Male Social Security Number _____

Occupation _____ Married Unmarried

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

If we call your emergency contact can we identify it is Planned Parenthood calling? YES NO

Ethnicity: <u>PLEASE CHECK ONE</u> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino
Race: <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian/Pac. Islander <u>MARK ALL THAT APPLY</u> <input type="checkbox"/> Amer. Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Other <input type="checkbox"/> Unknown/Not Reported

Do you have Oregon Health Plan, also known as Medicaid, welfare, OMAP/DMAP? Yes No

Required for program, if female: Number of pregnancies _____

If applicable, I authorize any insurance benefits to be paid directly to the clinic and authorize the clinic or insurance company to release any information required for a claim. I understand if my insurance does not cover all services and supplies I will be billed for the balance.

SIGNATURE: _____ DATE: _____

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

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

IF OHP: Secondary insurance coverage? Yes No

Client agrees to billing of secondary insurance? Yes No

Title X: GMI _____ FPEP _____ OHP # _____ Fee Level: _____

Updated Contact Information:

Date: _____ **Full Address:** _____

Home/Cell Phone: _____ Can we identify Planned Parenthood is calling? YES NO

Can we send mail related to your medical care in an envelope that says Planned Parenthood? YES NO

Date: _____ **Full Address:** _____

Home/Cell Phone: _____ Can we identify Planned Parenthood is calling? YES NO

Can we send mail related to your medical care in an envelope that says Planned Parenthood? YES NO