

PATIENT INFORMATION

PLEASE PRINT

Last Name: _____ First Name: _____ M.I.: _____

Preferred Name: _____

Date of Birth: _____ - _____ - _____ Social Sec. #: _____ - _____ - _____ Gender: M F MtF FtM

Address: _____ City: _____ State: _____ Zip Code: _____

Preferred Phone: (____) _____ Type: Home Work Cell Other

May we contact? Yes No May we leave a message? Yes No Best time to contact: _____

Alternate Phone: (____) _____ Type: Home Work Cell Other

May we contact? Yes No May we leave a message? Yes No Best time to contact: _____ E-mail: _____

Race/Ethnicity: (Please check all that apply)

White Black Hispanic American Indian Alaskan Native Asian Pacific Islander

Other Unknown

Hispanic Origin? Yes No

Primary Language: _____ Relationship Status: Partnered Married Separated Divorced Single

For billing and/or medical notification purposes (only our street address appears):

____yes, I can get mail at home

____or, at alternate mailing address: Name of homeowner or c/o: _____

Address: _____

City: _____ State: _____ Zip Code: _____

How did you hear about Planned Parenthood? _____

Highest grade of School Completed _____ Student: Yes No Full-Time Part-Time School: _____

Employed: No Yes FT PT Employer: _____ Phone #: (____) _____

Monthly Income: _____ per _____ (weekly, monthly, etc.) This supports _____ people, including myself.

Pay Stub Unemployment Book Self Pay (No Insurance)

EMERGENCY CONTACT PERSON- This person may be contacted if we cannot reach you.

Contact Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Relationship: _____

Phone: (____) _____ Type: Home Work Cell Other

Alternate Phone: (____) _____ Type: Home Work Cell Other

FULL PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED.

STATEMENTS ARE SENT WITHIN 30 DAYS FOR ANY UNPAID BALANCES.

INSURANCE: Please present your insurance card and a photo ID to the receptionist.

Insurance Type: _____ Policy # _____

Group # _____ Policy Holder _____

Relationship: Self Spouse Partner Child

I have chosen **NOT** to use my insurance coverage and agree to pay Planned Parenthood directly for any services rendered.

Your Insurance Company may send the subscriber an explanation of benefits if services are denied

(PLEASE COMPLETE AND SIGN REVERSE SIDE)

Patient given Bill of Rights Date _____ Signature _____

OTHER HEALTH CARE PROVIDERS

Please list your current health care providers: None

PREGNANCY HISTORY

You may be eligible for "Free Family Planning Services". Have you received Medicaid in the last 2 years? Yes No
Were you pregnant within the last 2 years? Yes No
If both answers are yes, date pregnancy ended? _____

CONTACT INFORMATION FOR MEDICAL PURPOSES - Accurate contact information is necessary for us to notify you of any suspected or detected abnormal findings. We must have a way to contact you by phone or mail. If all attempts to contact you fail, you may receive a certified letter.

May we contact you at your home phone? Yes No May we leave a message? Yes No
May we contact you at your work phone? Yes No May we leave a message? Yes No

Comments: _____

CONSENT FOR EXAMINATION AND SERVICES

I hereby give my consent to Planned Parenthood, its employees, and other authorized providers for:

! LABORATORY TESTING

I release Planned Parenthood and employees from all liability related to laboratory tests and any diagnostic errors based on test results. I also understand that Planned Parenthood is required by law to report positive test results for gonorrhea, chlamydia, syphilis and HIV to public health agencies.

! GUARANTEE OF CLINIC BILL

I agree to pay **Planned Parenthood** for services rendered, and understand that I am entitled to a satisfactory explanation of charges. **Planned Parenthood** is dedicated to providing health care based upon a patient's ability to pay. If I am unable to meet this obligation I will advise the appropriate staff and request consideration of a payment plan.

I understand that I will be responsible for any co-payments, deductibles and/or non-covered charges.

(Please answer the following questions)

Do you have a Health Care Proxy? Yes ___ No ___
If yes, may we have a copy for our files? Yes ___ No ___
If no, would you like information concerning Health Care Proxy? Yes ___ No ___
Information was provided.

Patient Signature

Planned Parenthood Staff Signature

Date

TO AVOID USE OF A COLLECTION AGENCY, PLEASE CONTACT THE BILLING DEPARTMENT IF PAYMENT WILL BE DELAYED.

Staff use only: Proof of ID: _____ Date: _____ Staff Initials: _____

Proof of ID: _____ Date: _____ Staff Initials: _____