

**REGISTRATION SHEET – PLEASE PRINT**

Please be sure you fill in this form correctly & completely, sign & date at the bottom.

Your privacy is just as important to Planned Parenthood (PP) as your health care. With your permission, your contact information will be used by PP for appointment reminders, to send a monthly statement if you have an outstanding balance, or when we need to get in touch with you about your test results. When it is medically necessary, we may try to reach you through your home address or alternate contact (someone else who will be able to get in touch with you.) If you do not answer our calls or letters regarding an abnormal test, we will also try to reach you through your emergency contact below. We will be as careful as possible to protect your confidentiality, and will make *every effort* not to reveal the details of the situation to anyone except you.

YOUR LAST NAME		FIRST NAME		MI		
YOUR MAILING ADDRESS		APT #	CITY	COUNTY	STATE	ZIP CODE
<b>May we send mail to you at this address?</b>		<input type="checkbox"/> Yes		<input type="checkbox"/> No		
<b>IF NO, you must give us another address where we can send mail to you.</b> In care of (NAME):			ALTERNATE MAILING ADDRESS (+ city, state, ZIP code)			

PLEASE ✓ WHICH NUMBER IS THE BEST ONE FOR US TO CALL

<input type="checkbox"/> YOUR HOME PHONE ( )	<input type="checkbox"/> YOUR WORK PHONE ( )	<input type="checkbox"/> YOUR CELL PHONE ( )
YOUR EMAIL ADDRESS ( we will not sell or give your email address to anyone else)		ANY OTHER CONTACT INFORMATION YOU WANT US TO USE (if someone else's info, please tell us who we'll be contacting on your behalf)

*When calling me, PP staff should:*

Identify themselves as Planned Parenthood       Identify themselves only as my "doctor's office."

**Who should we contact in case of an emergency? Name** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

YOUR SOCIAL SECURITY #	YOUR DATE OF BIRTH / /	YOUR SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	YOUR MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married
YOUR RACE <input type="checkbox"/> Caucasian (W) <input type="checkbox"/> Black (African-American) <input type="checkbox"/> Asian <input type="checkbox"/> Multiracial <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other		YOUR ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	

HIGHEST GRADE COMPLETED (1-16)	I HAVE A: <input type="checkbox"/> High school diploma <input type="checkbox"/> GED <input type="checkbox"/> Neither	ARE YOU A STUDENT NOW?    IF YES: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PART-TIME <input type="checkbox"/> FULL TIME	NUMBER OF CHILDREN BORN TO YOU THAT ARE LIVING NOW
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Do you need an interpreter?     No     Yes    **What language?** \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

**FOR OFFICE USE ONLY**

ENTERED BY	DATE	REVIEWED BY	DATE	REVIEWED BY	DATE	REVIEWED BY	DATE