



CLIENT REGISTRATION INFORMATION

Name :		Last	First	Middle Initial
Social Security #	Date of Birth	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Income (before taxes) \$ _____ per Month <small>(SELF, legal spouse, dep children)</small>	Family Size <small>(SELF, legal spouse, dep children)</small>
Best Mailing Address: (e.g., Billing or Apt reminders)			CITY	STATE
Alternate Mailing Address :			CITY	STATE
If we need to contact you by mail , can the envelope say "Planned Parenthood"? <input type="checkbox"/> Yes <input type="checkbox"/> No* *If NO, <u>we will</u> use an envelope with only our return address "3225 Timber Fall Court, Eureka"				
Confidentiality Notice: We will contact you in case of abnormal lab results or unpaid fees. <u>You must provide a way for us to contact you BY PHONE:</u>				
Best Daytime Phone #: ()	Type of phone #? (home, cell, work, other _____)	OK to say Planned Parenthood? (When calling or leaving a message.) <input type="checkbox"/> Yes, <input type="checkbox"/> No, say "Doctors Office", <input type="checkbox"/> No, use Code Name _____		
Alternate Phone#: ()	Type of phone #? (home, cell, work, other _____)	OK to say Planned Parenthood? (When calling or leaving a message.) <input type="checkbox"/> Yes, <input type="checkbox"/> No, say "Doctors Office", <input type="checkbox"/> No, use Code Name _____		
Emergency Contact (Required): Name Relationship to You Phone Number OK to say Planned Parenthood? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<i>Your Workplace and/or School Name:</i>				
Which of the following groups do you most closely identify with: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Multiethnic <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> White <input type="checkbox"/> Hispanic/ Latino				
Funding for our Services: <input type="checkbox"/> HAP Card (teal/green card) <input type="checkbox"/> Medi-Cal <input type="checkbox"/> CMSP <input type="checkbox"/> Medicare <input type="checkbox"/> Insurance <input type="checkbox"/> HMO Insurance <input type="checkbox"/> Private Pay (Self Pay) <input type="checkbox"/> Other				
Our funders want to know: When you are sick or injured, how do you pay for your health care at your doctor's office or the hospital: <input type="checkbox"/> Public Insurance: i.e. Medi-Cal/CMSP/Healthy Families <input type="checkbox"/> Private insurance <input type="checkbox"/> No Insurance				
TREATMENT AND PAYMENT AGREEMENT				
The preceding information is true to the best of my knowledge. I request Six Rivers Planned Parenthood to provide me with medical care. <u>I acknowledge my responsibility to pay for that care according to the fees established.</u> Furthermore, I authorize assignment of benefits for medical service to be paid to Six Rivers Planned Parenthood. I understand that use of any medical insurance or state funding means that Planned Parenthood may release information to the insurance company or the State of California about my diagnosis and care. I understand that Six Rivers Planned Parenthood uses outside laboratories for some of their tests. I understand that I may receive a bill from the outside lab if my insurance does not cover the cost of the test. I understand that I will be billed for charges not covered by my insurance company or other funding programs.				
Signature _____			Date _____	