



Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____
 Social Security Number: _____ - _____ - _____ Birth Date: ___ / ___ / _____ Sex: Female Male
 Mailing Address: _____ City: _____ State: _____ Zip: _____
 Alternate Address: _____ City: _____ State: _____ Zip: _____
 Daytime Phone: (____) _____ **Is it ok to say Planned Parenthood if we call?**
 YES NO, say Doctor's Office NO, say _____
 Alternate Phone: (____) _____ **Is it ok to say Planned Parenthood if we call?**
 YES NO, say Doctor's Office NO, say _____

Emergency Contact (Required for services)

Phone: (____) _____ Name: _____ Relationship to you: _____
 Is it ok to say Planned Parenthood if we call this number? YES NO

Contact Preferences

- If we need to contact you by mail, should the envelope say: Planned Parenthood Return address only
- Would you like to be on the Six Rivers Planned Parenthood mailing list (newsletters, events, and service announcements)?
 YES, use mailing address YES, use alternate address NO

Demographic Information (check only one box for each category)

Race <input type="checkbox"/> African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> None of the Above/Other	<input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Multi-racial	Ethnicity Do you consider yourself to be Hispanic or Latino? <input type="checkbox"/> YES <input type="checkbox"/> NO	Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____
--	---	---	--

Insurance / Funding for services

- Do you have a teal/green Family PACT card? YES NO
- Do you currently have Medi-Cal? YES NO
- Are you covered by health insurance under yourself, your spouse, or your parents? YES NO
- Check any reasons you cannot use your Medi-Cal or insurance today:
 Confidentiality (your family might find out) A share of cost or unmet deductible
 Insurance doesn't cover birth control Other: _____

Special Populations We are required by the agencies that provide us funding to ask you these questions. Your answers are confidential.

- Are you homeless or living in a shelter? YES NO
- Do you have a physical or mental condition that severely limits daily activities? YES NO
- Do you currently have a substance abuse problem? YES NO

Family Size & Income (include self, legal spouse, dependant children)

▪ Household income before taxes \$ _____ per month ▪ Family Size _____

Payment & Treatment Agreement

The above information I have provided is true. I request Six Rivers Planned Parenthood to provide me with medical care. I authorize assignment of benefits (payments from a third party) for medical service to be paid to Six Rivers Planned Parenthood. I agree to receive a bill and pay the full price for services not covered by my health insurance or reimbursed by other funding programs. 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 may use 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.

Signature: _____ Date: ___ / ___ / ___