

Today's Date:	Account Number:	MRN Number:
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PATIENT INFORMATION

Patients Last Name:		First Name:		Middle Initial:	
Address:			City:		
State:	Zip Code:	Can we send Mail to this address? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> PP Return Address		Special Mail Instructions:	
Email Address: (Optional)		Can we send you email? <input type="checkbox"/> Yes <input type="checkbox"/> No	Home Phone:		<input type="checkbox"/> PP <input type="checkbox"/> Code
Work Phone:	<input type="checkbox"/> PP <input type="checkbox"/> Code	Cell Phone:		<input type="checkbox"/> PP <input type="checkbox"/> Code	
Emergency Phone:	<input type="checkbox"/> PP <input type="checkbox"/> Code	Emergency Contact Name & Address:			

Marital Status: <input type="checkbox"/> Single/Never Married <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Other		Social Security Number:	Date of Birth: / /
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Have you been seen at any of our other locations? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Which Location? <input type="checkbox"/> Clermont <input type="checkbox"/> Dayton <input type="checkbox"/> Fairborn <input type="checkbox"/> Hamilton <input type="checkbox"/> Cincinnati <input type="checkbox"/> Glenway <input type="checkbox"/> Middletown <input type="checkbox"/> Springdale <input type="checkbox"/> Springfield		

EXTENDED DEMOGRAPHICS

County:	Race: <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan		
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Pacific Islander <input type="checkbox"/> Multi/Bi-Racial <input type="checkbox"/> Other		
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed	Student Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not a Student	Highest Grade Completed?	Number of Living Children?

Current Birth Control Method:

INSURANCE AND BILLING INFORMATION

Would you like us to bill your medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, complete insurance information below.</i>		
<input type="checkbox"/> Medicaid	Medicaid/Medicaid HMO Name	Medicaid Number
<input type="checkbox"/> Private/Commercial	Insurance Name	Policy Number
	Carriers Name:	Carriers Date of Birth:

PPSWO FINANCIAL AND CONFIDENTIALITY POLICIES

Planned Parenthood will submit your insurance claim for you if we are a provider with your insurance company and you are covered on the date of service, but coverage is not guaranteed. Co-pay, if applicable, is due at the time of service. If your claim is denied, you will be charged for services rendered. Accounts are considered past due after thirty (30) days. Please call to make payment arrangements if you are unable to pay the full amount when you receive a bill. If your check or credit card transaction is rejected, you will be charged a fee either by Planned Parenthood or by our check processing service. Remember, if you ask us to bill an insurance company or Medicaid for services, they may be under no obligation to keep your information confidential. Payment is expected at the time of service. Payment may be made by cash, check or credit card. We also accept Medicaid and private insurance. All information is confidential. Nothing will be released without your written permission, except as required by law. By signing below, you are authorizing us to release your confidential information, on an as needed basis only, to a physician in a medical emergency, to our legal counsel, our business associates, and insurance or Medicaid for billing purposes. **In the case of a serious medical problem, if attempts to contact you through your emergency contact are not successful, we reserve the right to call or write to you at your current/permanent address.*

I understand and agree to the Confidentiality Policy and the Financial Policy.

Patient Signature:	Date:
Staff Signature and Title:	Date: