Tri-Rivers Planned Parenthood®, Inc.

P.O. Box 359
Rolla, MO 65402
573-364-1509

2545 Bagnell Dam Blvd. Ste. 209
Lake Ozark, MO 65049
573-365-3244

P.O. Box 763
Kirksville, MO 63501
660-665-5672

S.S.#:_____/_____/_______ DATE OF BIRTH:_______________ DATE:____________________

NAME:____

ADDRESS:___________________________ CITY:____________________ STATE: ____ ZIP:_________

COUNTY:____________ HOME PHONE:________________ WORK PHONE:____________________

PLEASE COMPLETE IF YOU HAVE A PERMANENT ADDRESS OTHER THAN ABOVE:

ADDRESS:________________________________CITY: ________________ STATE: ____ ZIP: _______
COUNTY:_____________________ HOME PHONE:_____________________

Please circle all the ways we may contact you: Call Home Call Work Write Home(Plain Envelope)
Other____
Would you like information on getting birth control through the mail? ____ Yes ____ No
If you are less than 18, do your parents/guardians know that you get health care at TRPP?___Yes___No
If you are over 18, do you live with your parents/guardians at any time during the year? ____ Yes ____ No

CONFIDENTIALITY MAY BE BROKEN IF A LIFE THREATENING CONDITION IS SUSPECTED OR DETECTED.

EMERGENCY CONTACT PERSON:
Name____Relationship___________________________
Full Address:____________________________________Phone (   )___________________________

Sex: ____Female ____Male
Circle Your Race(Circle All That Apply): White Black Native American/Alaska Native Asian
Native Hawaiian/Other Pacific Islander
Are you Hispanic/Latino/Latina? ____ Yes ____ No
Circle your marital status: Single Married Separated Divorced Widowed Living Together
Are you a student? ___ Yes ___ No If yes, where? _______________________

Medical records will be destroyed after the elapsed time allowed by law.

I hereby certify that the above information is true and accurate to the best of my knowledge. I realize that this information is being given in connection with the receipt of federally subsidized health care. I further realize that deliberate falsification of this information may result in the termination of service.

PATIENT SIGNATURE:_______________________________________DATE:____________________

STAFF SIGNATURE:____ DATE:____________________