Planned Parenthood®
Planned Parenthood of the Heartland

## PATIENT REGISTRATION INFORMATION

Name: _____
Last First MI Maiden

Social Security Number: _____ Birth Date: _____ Age: _____ Sex: _____

*Your information is confidential. However, we must have a **phone number** and **address** where we can contact you.*

We will attempt to contact you by mail or phone for the following reasons:
1) To inform you or follow up with you regarding any abnormal issues found during your visit or abnormal results following your visit.
2) If required by state law.
3) To address payment due.

Address: _____
Street

_____
City State Zip County

If you are a minor, are you requesting confidential services from billing? ☐ Yes ☐ No

Day phone: _____ Home phone: _____ Cell phone: _____

Which numbers may we use to contact you? ☐ Day phone ☐ Home phone ☐ Cell phone

May we leave a message at these numbers?
☐ Yes ☐ No, but I understand that I may be contacted by phone and/or in writing in the event of an abnormal/positive lab result.

E-Mail Address: _____

What is your primary language? ☐ English ☐ Spanish ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Student Status: ☐ Not a student ☐ Full time ☐ Part time

Highest level of schooling completed:
☐ 8th grade or less ☐ 9th-12th grade, no diploma ☐ High School diploma ☐ Some college, no degree
☐ Associate's Degree ☐ Bachelor's Degree ☐ Post Graduate Degree ☐ Unknown

Race:
☐ American Indian/Alaska Native ☐ Multi-Racial ☐ Unknown
☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other: _____
☐ Black or African American ☐ White

Ethnicity: ☐ Hispanic or Latina/Latino ☐ Non-Hispanic

Emergency Contact: _____
(must be **over 18**) Name Phone Relationship

I have the following. (Check all that apply):
☐ Medicaid ☐ Medicare ☐ Private Insurance: _____

Do you plan to use your insurance coverage today? Yes/No
If you answered No, why not? _____

Planned Parenthood of the Heartland provides services and supplies on a discounted basis depending on income and family size.

☐ I wish to declare my income in order to determine if I qualify for a discount. (I will provide staff with income documents.)
☐ I prefer **not** to declare my income and understand that I will be responsible for the full price of all services incurred.

Please complete if you would like a discount for services:

| **I am employed:** | **I am paid:** | **My spouse is employed:** | **My spouse is paid:** |
|---|---|---|---|
| Yes/No | Weekly/Bi-Weekly/Monthly/Annually | Yes/No/NA | Weekly/Bi-Weekly/Monthly/Annually |

I receive unemployment benefits and/or have other sources of income: Yes/No

Number of children _____ supported by this income
(under 18 & living with you)

Total Family Size _____
(yourself, spouse & children living with you)

*It is Planned Parenthood of the Heartland's practice to bill all accounts that are not paid in full at the time of service.*

_____ | _____
Patient Signature Date

Name: _____
Birthdate: _____
PPHeartland Num: _____