PLANNED PARENTHOOD OF HAWAII
Patient Registration Form

PPHI recognizes that there is a spectrum of genders but many funding agencies and legal entities do not. Due to circumstances beyond our control, please be aware that the legal name and sex you have listed on your funding source must be used on documents pertaining to insurance and billing. If your preferred gender, name, and pronoun are different from these, please let us know

Current gender identity ❑ Male ❑ Female ❑ TG (MTF) ❑ TG (FTM)

Legal gender ❑ Male ❑ Female

Preferred Name_____

Preferred Pronoun _____

First Name	MI	Last Name
Street Address(Line1)		
Street Address(Line2)		
City	State	Zip Code
County		
Social Security Number		
Date of Birth	Age	
Home Telephone or Cell Phone		
Work Telephone		
Emergency Telephone # / Contact Name / Relationship		
Who can we say is calling? Circle one: PPHI Dana Other Code Name		
How can we send you mail? Circle one: PPHI ID OK PPHI Address Only		
Email Address		
Can you receive Email Circle one: Yes No		
Birth Gender Circle one: Male Female		
Ethnicity – Circle All That Apply: African American Korean Samoan American Ind/AK Native Laotian Vietnamese Caucasian/White Marshallese Other Asian Chinese Micronesian Other Pacific Isl. Filipino Portuguese Guamanian Hawaiian/Part Hawaiian Puerto Rican/Mexican/Cuban Japanese		
Hispanic Origin Circle one: Hispanic Non-Hispanic		
Marital Status Circle one: Divorced Single Live Together Married Widowed Separated		

How were you referred to this clinic
Are you a student Circle one: Yes No
If you are a student, what type of student Circle one: Junior High High School College Graduate School
What is the highest grade of school you completed
Citizen Status Circle one: U.S .Citizen Refugee Student Visa Tourist Visa Immigrant Other Compact States (Palau, Micronesia or Marshal Islands)
Homeless Status Are you homeless or living in a transitional shelter? Circle one: Yes No
How will you be paying for this visit Circle one: Health insurance Self-Pay
Do you have Health insurance Circle one: Yes No Primary insurance:_____ Subscriber #: _____ Other insurance: _____ Subscriber #: _____ Please remember that insurance may not cover all fees for your services. It is your responsibility to pay any deductible, co-pay, or any other balance not paid by your insurance. I authorize Planned Parenthood of Hawaii to release my medical records to any organization or agency which is or may be liable for any portion of the charges for my service. Signature: _____ Date of Signature: _____