Planned Parenthood®
Care. No matter what.
Planned Parenthood Hudson Peconic

Today's Date

please print clearly * = required information

Reason for your Visit today :

PATIENT CONTACT INFORMATION

*Last Name	* First Name	M.I
**Please provide maiden name here (if applicable)		
*Street Address		
*City	*State	*Zip

*Phone	Home ( )	email address: _____
	Work ( )	
	Cell ( )	

How would you like to receive appointment reminders? _____Voice mail _____Text

Note: *If any of your test results are abnormal, we **MUST** be able to reach you!*

If we call you, can we say: Planned Parenthood? _____ YES _____ NO

If we send mail, can it be in a Planned Parenthood envelope? _____ YES _____ NO

Please note that if you have insurance coverage, you may receive an "explanation of benefits" from your insurance.

EMERGENCY CONTACT

NAME RELATIONSHIP

PHONE ALTERNATE PHONE

PATIENT INFORMATION

*Date of birth: / /

*Gender: ◯Female ◯ Male

Social Security number: - -

◯ Transgender: prefer He / She (circle one)

*Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Domestic Partner ◯ Legally Seperated

Are you currently employed? ◯ Yes, Full Time ◯ Yes, Part Time ◯ No

Employer Name: _____

*Total Income: $_____per (circle one) **Annual, Monthly, Every 2 wks, Weekly** ____ # of people salary supports

(Income includes: salary, alimony, unemployment, pension, disability and any other income)

Are you a student? ___Yes, Full Time ___Yes, Part Time ___No

Highest grade completed: (Please circle): 8, 9, 10, 11, 12, 13, 14, 15, 16 Other: _____

Have you ever been pregnant? ____Yes ____No **Date last pregnancy ended: / /**

Did you have Medicaid when your last pregnancy ended? ____Yes ____No

PATIENT PHARMACY INFORMATION

Pharmacy Name:

Pharmacy Address	City	St	Zip

Telephone	Fax	email

PATIENT INSURANCE INFORMATION

Do you have insurance? ____Yes ____No If Yes, what? O Medicare or Medicaid O FPEP O FPBP
O Medicaid Managed Care O Private Insurance

If Medicaid Managed Care or Private Insurance, name of Insurance plan:_____

Policy holder name_____ Subscriber # _____

Relationship to Policy holder: ____Self ____Spouse ____Child ____ Other: (please specify) _____

Please be advised that, with the exception of co-pays and any other charges Group # _____
that you are responsible for under the terms of your plan, all client pymts will be applied first to any past-due balances

ETHNICITY AND RACE INFORMATION

Please answer these questions to assist us with providing culturally competent services.

Ethnicity: Please select the statement that best describes you

- ◯ Hispanic/Latino
- ◯ Non-Hispanic
- ◯ Refused to report

Race: Please select the statement that best describes you

- ◯ Black/Afr American
- ◯ White
- ◯ Asian or South Asian
- ◯ Alaska Native
- ◯ Native Hawaiian
- ◯ American Indian
- ◯ Other Race/Multiracial:
  print race(s) _____

What language do you want to get services in today? ◯ **English,** ◯ **Spanish,** ◯ **French,** ◯ **Creole,** ◯ **Other:**_____

Would language interpreter services be helpful to you during your visit? _____Yes _____No

HOW DID YOU HEAR ABOUT PLANNED PARENTHOOD?

O Person or information at my door O Dept of Social Services O Friend O Family O Facebook/MySpace
O Internet O Medical Provider O Mobile phone Text Message O Phone Book O Physician O Radio Ad
O Referral O School Referral O Smart Wheels Van O Train or Bus O TV Ad O Other_____

PATIENT CONSENT

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

- I voluntarily consent to the necessary procedures and medications needed for the care I have requested and allow Planned Parenthood to contact me through phone, text, and/or the patient portal about test results, appointments and other issues concerning my health.
- I authorize the release of any medical or other information necessary to process an insurance claim.
- I also request payment of government benefits, either to myself or the party who accepts assignment below if I have government insurance.
- I understand that Medicaid is the Payer of Last Resort (OLR) and that if I have Medicaid and another insurance, in which Planned Parenthood Hudson Peconic participates, that I must use the other insurance first.
- I attest that the insurance information I provided was accurate and complete.
- I understand that if I would like to designate a health care proxy, I should request a proxy form from Planned Parenthood staff.
- I understand that by signing below, I am allowing Planned Parenthood HP to see information about medications that I am . already taking, or have taken, to minimize the possibility of an adverse drug event.

Signed: _____ Date: _____

Relationship to patient: _____ Date: _____

Staff Witness: _____ Date: _____

FOR OFFICE USE ONLY

Validation of Pt Financial and Demographic data

□ Pt reg form fully completed & scanned in eCW
□ Pt ID scanned in eCW
□ Pt ins card scanned in eCW
□ Pt reg info updated in eCW
□ Pt income (pay stub) or attestation scanned in eCW (FP & Colpo only)
□ Pt eligibility for FPBP, FPEP & Presumptive, verified
□ FPBP, FPEP, Presumptive eligibility forms completed & scanned
□ Patient's income level calculated using Federal Poverty Guidelines instruction

Data reviewed & entered by:
(please print or use stamp)
Name:

Date: