Planned Parenthood®
Care. No matter what.
Planned Parenthood Mar Monte

Visit Date _____ **Client Number** _____

CLIENT REGISTRATION INFORMATION

_____ _____ Sex: M❑ F❑ ___/___/___ ___/___/___
Last Name First Name Date of Birth Social Security Number

_____
Mailing/Billing Address: Street Number Street Name Apt. Number City State Zip Code

Address where you live (if different from above): _____

The government funding we receive require the following information:

What is your race?

❑ African American (Black) ❑ Multi-racial ❑ American Indian or Alaska Native ❑ Other race
❑ Asian ❑ White ❑ Pacific Islander — Native Hawaiian

Ethnicity: Are you hispanic? ❑ Yes ❑ No

What is your primary language?

❑ English ❑ Cambodian ❑ Chinese ❑ Khmer ❑ Tagalog
❑ Spanish ❑ Cantonese ❑ Hindustani ❑ Russian ❑ American Sign Language
❑ Vietnamese ❑ Armenian ❑ Laotian ❑ Portuguese ❑ Punjabi
❑ Arabic ❑ Hmong ❑ Japanese ❑ Korean ❑ Other

Do you have a primary care provider (PCP) who you must see? ❑ Yes ❑ No Name of PCP: _____

Marital Status: ❑ Divorced ❑ Legally Separated ❑ Married ❑ Single ❑ Single w/Partner

Are you a US Veteran? ❑ Yes ❑ No

If we need to contact you, which phone number(s) should we use? May we leave automated messages at the number(s) below? ❑ Yes ❑ No

Preferred: _____ Cell phone? ❑ Yes ❑ No Alternate: _____ Cell phone? ❑ Yes ❑ No

How shall we identify ourselves? ❑ Planned Parenthood ❑ Doctor's Office ❑ Friend ❑ Other _____

Which option best describes your current housing situation?

❑ (1) Renting a Motel Room
❑ (2) Staying in a Car, Camper or Camping
❑ (3) Staying at a Shelter or Shelter Program
❑ (4) Transitional Housing Program
❑ (5) Staying temporarily with friends or family
❑ (6) Rent with others (6 months or less and more than 3 people per bedroom)
❑ (7) Rent alone or with others, fewer than 3 people per bedroom
❑ (8) Live in a home owned by you or your family
❑ (9) Other
❑ (10) Decline to state

Are you a migrant worker? ❑ Yes ❑ No

Do you need someone to translate for you from English to your primary language? ❑ Yes ❑ No
(We do not recommend that family and/or friends translate for you.)

Emergency Contact Name: _____ Telephone Number: _____

Do you have any of the following? (Check all that apply):

❑ Medicaid/Medi-Cal ❑ Medicare ❑ Teal/Green "Health Access Program" card / Family PACT (for CA only)

❑ Private/Commerical Insurance — Please specify: _____

Does your insurance cover contraceptive services? ❑ Yes ❑ No ❑ Don't know

Check any reasons you cannot use your health coverage/insurance today:

❑ Confidentiality (your family might find out) ❑ Share of cost or unmet deductible ❑ Insurance does not cover birth control ❑ Other

Your Gross Monthly Income before taxes (Please include your spouse's income if you are married): $ _____ /month

Number of *your* children 18 and under living with you: _____ ❑ Decline to state

We need this information to determine your eligibility for government funds. If you prefer to decline stating your income and/or your family size you will be charged accordingly based on our fee schedule. All information is confidential.

The information I have provided is true. I agree to pay the full price for services not covered by my health insurance or reimbursed by a third party. I understand I am ultimately responsible for payment of services rendered.

SIGN HERE: _____ **DATE:** _____

Original filed in Client Chart; Copy to Billing