PLANNED PARENTHOOD OF GREATER TEXAS

PATIENT REGISTRATION

While PPGT recognizes that there is a spectrum of genders, 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 name and pronoun are different from these, please let us know.

Personal Information

Last Name	First Name	MI	Preferred Name / Nickname		Date
Social Security Number			Date of Birth	Age	Preferred method of contact ☐ Phone ☐ Mail ☐ Either
Street Address (Primary Contact)		Apt. #	City	State	Zip Code
Street Address (Secondary – ex. billing, if different)		Apt. #	City	State	Zip Code
E-mail address			Preferred language		
Primary Phone	☐ Cell ☐ Home ☐ Work		Secondary Phone	☐ Cell ☐ Home ☐ Work	

Sexual Orientation and Gender Identity

Preferred Gender Pronoun	Sex assigned at birth
☐ She ☐ He ☐ They ☐ Other:	☐ Female ☐ Male ☐ Intersex
Do you think of yourself as	Do you think of yourself as
☐ Straight/heterosexual ☐ Gay/lesbian/homosexual	☐ Female ☐ Female-to-male (FTM)/transgender man
☐ Bisexual/pansexual ☐ Asexual	☐ Male ☐ Male-to-female (MTF)/transgender woman
☐ Questioning/don't know ☐ Decline to answer	☐ Genderqueer ☐ Decline to answer
☐ Other:	☐ Other:

Demographic Information

Ethnicity	Race			
☐ Hispanic or Latino	☐ African American	☐ Multiracial	☐ Pacific Islander	☐ Unknown
☐ Not Hispanic or Latino	☐ Asian	☐ Native American	☐ White	☐ Other:

Emergency Contact Information

Name/Relationship of Emergency Contact	Phone # of Emergency Contact

Income & Insurance Information

Family Size	Monthly Income	Do you have insurance? ☐ Yes ☐ No
	$	If yes, please provide card.
Do you have Medicaid/WHP? ☐ Yes ☐ No		*Travis County residents only*:
Medicaid # (if applicable)		Do you have the MAP (Medical Access Program) card? ☐ Yes ☐ No

How did you hear about us?

☐ Been to Planned Parenthood Before	☐ Health Clinic/Doctor Referred Me	☐ On-line (Google; Facebook; etc.)
☐ Friend/Family Recommended	☐ Marketing Event	☐ Saw/Heard a Planned Parenthood Ad
☐ Other:		

FOR CLINIC STAFF USE ONLY	Patient Name:
	DOB:
	MR#:

PLANNED PARENTHOOD OF GREATER TEXAS

Marital status			
☐ Married	☐ Domestic Partnership	☐ Widowed	☐ Single with Partner
☐ Divorced	☐ Legally Separated	☐ Single	

Reproductive History			
# of Pregnancies	# of Live Births	# of Living Children	Year & Month of Last Live Birth (YYYYMM)
Current Birth Control Method ☐ N/A			

Preferred Pharmacy Information	
Name of Preferred Pharmacy	Phone # of Preferred Pharmacy
I authorize the following people to pick up my medications:	

FOR CLINIC STAFF USE ONLY	Patient Name:
	DOB:
	MR#: