Planned Parenthood®
Care. No matter what.

Planned Parenthood California Central Coast
Patient Registration Form

Planned Parenthood is committed to maintaining client confidentiality and quality health care. There are times when we discover a medical problem that requires immediate notification.
We MUST know how you can be reached!

Last Name_____ First Name_____

Preferred Name_____ Preferred Pronoun (i.e. she/he/they) _____

Social Security Number _____ Date of Birth_____

Sex assigned at birth (circle one): Female Male

Address_____ City_____ State_____ Zip_____

Please give us a phone number where we can call you? _____
Do you have a 2nd phone number where we can call you? _____
Can we leave a message that Planned Parenthood Called? ____Yes ____No
If No, can we just leave a message that your doctor called? ____Yes ____No
If No, can we have a code name to use to leave a message? Code word_____

Racial Group (Please Check ALL that Applies)
_____ American Indian or Alaska Native _____ Asian _____ Black/ African American
_____ More than one race _____Native Hawaiian or other Pacific Islander
_____White (Caucasian/Hispanic) _____Other _____Unknown

Do you need our staff to speak to you in a language other than English? _____ Yes _____No
(If Yes circle one) Spanish Mixteco Tagalog Chinese Japanese Korean Vietnamese Portuguese Other _____

Ethnic Group _____Hispanic _____ Not Hispanic

Marital Status _____ Single _____Married _____Separated _____Divorced _____Life Partner

Emergency Contact Name _____PH#_____

Where did you hear about us?

___ Friend/Relative ___ Referred by Another Medical Provider ___ Website

___ Health educator in community ___Local Health fair ___ Other

 Please Complete the back side of this form.

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Do you have Health Insurance? _____No _____Yes (If yes please take your insurance card to reception)

Are you homeless? _____Yes _____No

Are you a Migrant Worker _____Yes _____No

Family Size (include self, spouse, children):_____

What is your **monthly** income (if MARRIED include spouse's income) $_____

Consent for Treatment/ Authorization to Bill insurance

You are financially responsible for all services provided. As a courtesy, we will bill your insurance. Your insurance will reimburse based upon your coverage, eligibility, deductible or co-pays. By signing this form, you understand that you are financially responsible for your medical care and agree, understand, and will adhere to our financial policy.

I hereby consent to and authorize the administration of all treatments that may be considered advisable or necessary in the judgment of Planned Parenthood. I authorize Planned Parenthood to furnish a copy of this report to my insurance carrier. I hereby authorize the staff of Planned Parenthood to furnish information to insurance carriers or a third party review organization concerning my illness and treatments and I hereby assign Planned Parenthood all payments for medical services. A photocopy of this authorization is valid as the original.

I authorize payment of medical benefits to the clinic for medical services received at PPCCC.

I authorize PPCCC to provide any information necessary for laboratory services. I understand that I may receive a separate bill for any outside services.

I understand that suspicions of child abuse and neglect, statutory rape, domestic violence and sexual assault are required to be reported by state law.

I agree to accept mail regarding my account at address provided on the previous page, or to enroll in the PPCCC Patient Portal to receive electronic account information.

_____ _____
Signature Date

Please return this form to the front desk. Thank you.