Check In Information



Planned Parenthood Great Plains

Date: Checl	k-in Time:	Reason for Visit:			
Name (First & Last):		_ Date of Birth:			
Does this match your current legal na	ame? YES / NO If NO:				
Home Address (including city, state,	and zip):				
Phone Number:	Can PPG	P leave a message at this number? Yes / No			
Email Address:	@	Patient Portal? Yes / No Thanks			
Emergency Contact's First Name:	Relation:	Phone Number:			
Please select the responses below the My pronouns:	nt best reflect your identities and Gender identity:	Sex assigned at birth (on original			
☐ She/her/hers	□ Woman	birth certificate):			
☐ He/him/his	□ Man	☐ Female			
☐ They/them/theirs	□ Non-binary	☐ Male			
☐ Ze/hir/hirs	☐ Agender	☐ Intersex			
☐ Another:	_ Another:				
	☐ Choose not to disclose	☐ Choose not to disclose			
	Do you identify as transger	nder? Yes / No			
Sexual orientation:	Marital status:	Race:			
☐ Straight	☐ Married	☐ Asian			
☐ Lesbian or gay	☐ Unmarried w/ partner	☐ Black or African American			
☐ Bisexual	☐ Divorced	☐ Native American			
☐ Asexual	☐ Single	☐ Pacific Islander			
☐ Another:	☐ Another:	□ White			
\square Choose not to disclose	☐ Choose not to disclose	☐ Another:			
		☐ Choose not to disclo			
		Are you Hispanic or Latino? Yes / No			

• Insurance Information:

Are you planr	ning to use insurance for this visit?	YES / NO						
Will you be so	ubmitting an electronic copy of your i	nsurance card? Y	YES / NO					
□ YES. I	By signing below, you are acknowled	ging electronic co	ommunication	n may not be secure.				
What type of	insurance(s)/coverage(s) do you have							
Who Carries th	is Policy? SELF / Another Person:							
Policy Holder's	Relation to you:	Policy Holder's Gender: M / F / Another						
Member/ID/Pol	Member/ID/Policy Number: Group Number (if applicable):							
For billing purp	ooses, if you have insurance, what gender of	lo they have on reco	ord for you? F	emale / Male / Another				
Name listed on	your insurance card:							
• Preferi	red Pharmacy: Name:	Location (Stre	eet):					
Phone Num	ber:							
• Educat	ion Level: High School / 2 Yr Degree	4 Yr Degree / Do	octorate / Som	ne College / Unknown				
• Currer	nt Student: YES / NO							
understand that I am Planned Parenthood. carrier. Depending or	on is true to the best of my knowledge. I author financially responsible for any balance. I und I also authorize Planned Parenthood to releas n your insurance we may need to contact your responsible for any services not covered by n	erstand that I may be se any information re policy holder for the	e billed separate quired from my ir signature in o	ly for lab services received at medical record to my insurance				
Patient Signature			Date					
Guarantor Signature			Date Phone Number					

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Planned Parenthood Great Plains

-----Title X Portion (For Use in Missouri Only) ------

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