Check In Information

Planned Parenthood®
Care. No matter what.
Planned Parenthood Great Plains

Date: _____ **Check-in Time:** _____**Reason for Visit:** _____

Name (First & Last): _____ Date of Birth: _____

Does this match your current **legal** name? YES / NO If NO: _____

Home Address (including city, state, and zip): _____

Phone Number: _____ Can PPGP 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 that best reflect your identities and background.

My pronouns:

- ☐ She/her/hers
- ☐ He/him/his
- ☐ They/them/theirs
- ☐ Ze/hir/hirs
- ☐ Another: _____

Gender identity:

- ☐ Woman
- ☐ Man
- ☐ Non-binary
- ☐ Agender
- ☐ Another: _____
- ☐ Choose not to disclose

Do you identify as transgender? Yes / No

Sex assigned at birth (on original birth certificate):

- ☐ Female
- ☐ Male
- ☐ Intersex
- ☐ Another: _____
- ☐ Choose not to disclose

Sexual orientation:

- ☐ Straight
- ☐ Lesbian or gay
- ☐ Bisexual
- ☐ Asexual
- ☐ Another:_____
- ☐ Choose not to disclose

Marital status:

- ☐ Married
- ☐ Unmarried w/ partner
- ☐ Divorced
- ☐ Single
- ☐ Another: _____
- ☐ Choose not to disclose

Race:

- ☐ Asian
- ☐ Black or African American
- ☐ Native American
- ☐ Pacific Islander
- ☐ White
- ☐ Another: _____
- ☐ Choose not to disclo

Are you Hispanic or Latino? Yes / No

- **Insurance Information:**

Are you planning to use insurance for this visit? YES / NO

Will you be submitting an electronic copy of your insurance card? YES / NO

☐ YES. By signing below, you are acknowledging electronic communication may not be secure.

What type of insurance(s)/coverage(s) do you have?

_____

Who Carries this Policy? SELF / Another Person: _____ Date Of Birth: _____

Policy Holder's Relation to you: _____ Policy Holder's Gender: M / F / Another

Member/ID/Policy Number: _____ Group Number (if applicable): _____

For billing purposes, if you have insurance, what gender do they have on record for you? Female / Male / Another

Name listed on your insurance card: _____

- **Preferred Pharmacy:** Name: _____ Location (Street): _____

  Phone Number: _____

- **Education Level: High School / 2 Yr Degree / 4 Yr Degree / Doctorate / Some College / Unknown**
- **Current Student: YES / NO**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Planned Parenthood. I understand that I am financially responsible for any balance. I understand that I may be billed separately for lab services received at Planned Parenthood. I also authorize Planned Parenthood to release any information required from my medical record to my insurance carrier. Depending on your insurance we may need to contact your policy holder for their signature in order to bill for services. I understand that I am responsible for any services not covered by my health insurance plan.

Patient Signature		Date	
Guarantor Signature		Date Phone Number	

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

INCOME INFORMATION (please list all household incomes)

Employer	Pay Before Deductions		
		Weekly	Monthly	Annually
Employer	Pay Before Deductions		
		Weekly	Monthly	Annually

Unemployment/Workmen's Comp _____ State Cash Assistance _____ Social Security_____

Child Support _____ Disability _____ Alimony _____ Other Source _____

# of people in household including self 1 2 3 4 5 6 _____

LEVEL	1	2	3	4	5	M/C	INS	Staff Signature

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Patient Signature		Date	
Guarantor Signature		Date Phone Number	

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Patient Signature		Date	
Guarantor Signature		Date Phone Number	