

STAFF ONLY

MR #: \_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Entered in NextGen \_\_\_\_\_\_ per \_\_\_\_\_\_

Staff Initial: \_\_\_\_\_\_\_ Fin Class: \_\_\_\_\_\_\_\_

Thank you for choosing Planned Parenthood.

Please print clearly; all **bold** **sections are required**.

We are here to help if you have questions or need assistance.

This form is required for all patients and is completed annually.

**First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Security Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address Line 1**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apartment Number: \_\_\_\_\_\_\_\_\_

**Address Line 2 City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_\_\_ **Zip Code**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Can we leave a voicemail?** \_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can we leave a voicemail? \_\_\_\_\_\_\_\_\_\_\_\_

**Passcode** to be verified over the phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We must be able to contact you by mail in case of abnormal test results or if you have a balance on your account. If you would prefer we use an alternate address to the one provided above, please write it here:

Address Line 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apartment Number: \_\_\_\_\_\_\_\_\_

Address Line 2 City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact** (please note if you are under 18, you MUST list a parent or guardian)

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who, if anyone, may have access to your Personal Health Information**:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Marital Status**:* Married
* Single
* Domestic Partnership
* Divorced
* Separated
* Widowed

**Student Status**:* Full-Time
* Part-Time
* Not in School
 | **Employment Status**:* Full-Time
* Part-Time
* Not Employed

**Sexual Orientation**:* Straight/ Heterosexual
* Gay/ Lesbian
* Bisexual
* Pansexual
* Asexual
* Other
 | **Highest level of education I have completed**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**What is your preferred language?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**When was the first day of your last menstrual period?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **First Time Patients Only**:Your privacy is important to us and we keep your personal information confidential. Our services are supported by state, federal, and private grants. In order for us to receive this money, we often need to answer questions related to overall patient demographics. Please help us provide services for patients that need financial help by providing this information. | **Which best describes your race?** * African American
* American Indian/ Alaskan Native
* Asian
* Multi-Racial
* Native Hawaiian/ Pacific Islander
* White
* Other:\_\_\_\_\_\_\_\_\_\_

**Do you consider yourself Hispanic or Latino?*** Yes
* No
 | **How did you hear about us?*** Community Event
* Facebook/ Social Media
* Friend/ Family Member
* Medical Office/ Clinic
* TV
* Internet:\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Planned Parenthood Program
 |



**Planned Parenthood requires that you provide us with your income information for statistical purposes.** Please take a moment to think about all sources of income including wages, salary, TANF, SSI, Social Security, Food Stamps, disability, unemployment, allowance, help from friends/ family, or other income. Do not include tuition benefits that go to your school or child support money that goes to your child(ren).

|  |  |
| --- | --- |
| **Please provide the ONE that best describes your income**:* My weekly income is: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* My monthly income is: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* My yearly income is: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* I work \_\_\_\_\_\_\_ hours per week at $ \_\_\_\_\_\_\_\_ per hour.
 | * My spouse/partner/parent weekly income is $\_\_\_\_\_\_\_\_\_\_
* My spouse/partner/parent monthly income is $\_\_\_\_\_\_\_\_\_\_
* My spouse/partner/parent yearly income is $\_\_\_\_\_\_\_\_\_\_\_

**How many people are supported with this income?** **\*\*\*This income supports ME(1) and \_\_\_\_\_\_ other people.\*\*\*** |

If you have **Medicaid**, write the number here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Circle which state: Missouri/ Illinois/ Kansas.

If you have **Commercial/ Private insurance**, what company is it through? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identification/ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-Pay: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have a **secondary insurance**, what company is it through? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identification/ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-Pay: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Please note: you are responsible for any unpaid balances not covered by your insurance policy, including deductibles, co-pays, and coinsurance. Any non-covered benefits or rejected claims are your responsibility.

If you **do not have insurance** or chose not to use your insurance, we will give you an estimate of what your charges will be before your visit. These charges will be due at the time of your visit.

**Please sign**:

* I certify that I have reported any and all of my insurance coverage to PPSLRSWMO to ensure proper billing.
* If applicable, I authorize any insurance benefits to be paid directly to the health center and authorize the health center or insurance company to release any information required for a claim.
* I am financially responsible for any balance due.
* If PPSLRSWMO are unable to reach me at my documented address, PPSLRSWMO may send mail to the address on file with my insurance company.
* I certify that the above information is accurate and complete. I am assigning all benefit payments to PPSLRSWMO for services rendered by PPSLRSWMO or its contracted vendors.

**SIGNATURE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE**: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_