

**STAFF ONLY**

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

**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**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birth Sex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Gender Identity**:   * Female * Male * Transgender Female/Trans Female * Transgender Male/Trans Male * Gender Queer * Choose not to disclose | **Sexual Orientation**:   * Straight or Heterosexual * Lesbian/Gay/Homosexual * Bisexual * Choose not to disclose * Don’t know * Something else, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Pronoun**:

* He/Him/His
* She/Her/Hers
* They/Them/Theirs
* Ze/Hir
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_
* Decline to answer

**We must be able to contact you by mail in case of billing inquiries, abnormal test results or if you have a balance on your account**.

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apartment Number: \_\_\_\_\_\_\_\_\_**

**City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Day Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Alternate Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For access to your patient portal provide an Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**To verify your identity via phone create a Passcode**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Marital Status**:   * Divorced * Domestic Partnership * Legally Separated * Married * Single * Widowed   **Race**:   * White * African American * American Indian or Alaska Native * Asian * Multi-racial * Native Hawaiian or Other Pacific Islander | **Student Status**:   * Full-Time Student * Not a Student * Part Time Student   **Ethnicity**:   * Hispanic or Latino * Not Hispanic or Latino   **Preferred Language**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **How did you hear about us**?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |  | | --- | --- | |  | **Employment Status**:   * Full-Time * Part-Time * Not Employed   **Highest Level of Education Completed**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  |  |  |

**Emergency Contact: Must be completed by ALL Patients. (If you are under 18, must be a parent)**

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

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

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

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



**Financial Information**

**\*\*\*Payment is expected at the time of services\*\*\***

My income is: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ weekly/monthly/yearly

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Staff initials that charted income in NexGen/ completed financial counseling: \_\_\_\_\_\_\_\_\_\_\_

**OR** My partner/parent income is $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ weekly/monthly/yearly.

This income supports \_\_\_\_\_\_\_people, including myself

* I refuse to declare my income and am aware I may not be eligible for discounted services

**Insurance Information**

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**: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

***Preferred Pharmacy Information:***

**Name of Pharmacy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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