

STAFF ONLY

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

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

Arrival Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**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. 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?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **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
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**Income Information**: 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Pharmacy Information:****Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone#**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please sign**:

* I certify that I have reported any and all of my insurance coverage to RHS of PPSLR 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 certify that the above information is accurate and complete. I am assigning all benefit payments to RHS of PPSLR for services rendered by RHS of PPSLR or its contracted vendors

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