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

Check In Information

Date: _____ **Check-in Time:** _____

Name (First & Last): _____ Date of Birth: _____
Does this match your current **legal** name? YES / NO If NO: _____

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

Is your address inside the city limits? YES / NO

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: _____

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

Please select the responses below that best reflect your identities and background some of the following questions are to help us give you the highest quality care, others are required by the state.

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

Sex assigned at birth (on original birth certificate):
- ☐ Female
- ☐ Male
- ☐ Intersex
- ☐ Another: _____
- ☐ Choose not to disclose

Do you identify as transgender? Yes / No

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 disclose

Hispanic Origins:

- ☐ Not Spanish, Hispanic, or Latina
- ☐ Mexican, Mex. American, or Chicana/o
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Central American
- ☐ South American
- ☐ Unknown/ Another: _____

Education Level:

- ☐ **No High School**
- ☐ **Some High School**
- ☐ **HS Diploma or GED**
- ☐ **Some College**
- ☐ **Associates**
- ☐ **Bachelor's**
- ☐ **Master's**
- ☐ **Doctorate/PhD**
- ☐ **Unknown or Decline to Say**

Payment Status:

☐ **I am paying for my care. (If so, sign below and** 

here.)

Patient Name	Date

☐ **I am using my Insurance (Please answer all questions below.)**

Insurance NOTE: All Insurance MUST be Pre-certified by the Call Center for Use.

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 company are you insured by?: _____

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): _____

What gender does your insurance have on record for you? Female / Male / Another

Name listed on your insurance card: _____

The above information is true to the best of my knowledge. I authorize my insurance benefit be paid directly to Planned Parenthood GP. I understand that I am financially responsible for any balance. I understand that I may be billed separately for lab services received a PPGP. I authorize PPGP to release any information required from my medical record to my insurance understand that I am responsible for any services not covered by my health insurance.			
Patient Signature		**Date:**	
Guarantor Signature		**Date:**	