

PATIENT IDENTIFICATION

PHYSICIAN INFORMATION

Last Name: _____ First Name: _____ M.D.: _____
Preferred Name: _____
Date of Birth: _____ Social Sec. #: _____ Gender: ☐ M ☐ F ☐ M/F ☐ Other
Address: _____ City: _____ State: _____ Zip Code: _____
Preferred Phone: (____) _____ Type: Home ☐ Work ☐ Cell ☐ Other ☐
May we contact? Yes ☐ No ☐ (May we leave a message? Yes ☐ No ☐ Best time to contact: _____
Alternate Phone: (____) _____ Type: Home ☐ Work ☐ Cell ☐ Other ☐
May we contact? Yes ☐ No ☐ (May we leave a message? Yes ☐ No ☐ Best time to contact: _____ If mail: _____
Race/Ethnicity: (Please check all that apply)

☐ White ☐ Black ☐ Hispanic ☐ American Indian ☐ Alaska Native ☐ Asian ☐ Pacific Islander
☐ Other ☐ Unknown

Hispanic Origin? ☐ Yes ☐ No

Primary Language: _____ Relationship Status: ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Single

For billing and/or medical notification purposes (only one street address appears):

____ yes, I can get mail at home

____ no, at alternate mailing address: Name of homeowner or CEO: _____
Address: _____
City: _____ State: _____ Zip Code: _____

How did you hear about Planned Parenthood? _____

Highest grade of School Completed: _____ Student: ☐ Yes ☐ No ☐ Full-Time ☐ Part-Time School: _____

Employed: ☐ No ☐ Yes ☐ FT ☐ PT ☐ Employer: _____ Phone # (____) _____

Monthly Income: _____ per _____ (weekly, monthly, etc.) This supports _____ people, including myself.
☐ I pay bills ☐ Use employment book ☐ Self pay (No insurance)

EMERGENCY CONTACT PERSON - This person may be contacted if we cannot reach you.

Contact Name: _____ Address: _____
City: _____ State: _____ Zip Code: _____ Relationship: _____
Phone: (____) _____ Type: Home ☐ Work ☐ Cell ☐ Other ☐

Alternate Phone: (____) _____ Type: Home ☐ Work ☐ Cell ☐ Other ☐

FULL PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED.

STATEMENTS ARE SENT WITHIN 30 DAYS FOLLOWING SERVICE RENDERED.

☐ **INSURANCE:** Please present your insurance card and a photo ID for the reimbursement.

Insurance Type: _____ Policy #: _____

Group #: _____ Policy Holder: _____

Relationship: ☐ Self ☐ Spouse ☐ Partner ☐ Child

☐ I have chosen **NOT** to use my insurance coverage and agree to pay Planned Parenthood directly for any services rendered.

Your Insurance Company may send the subscriber an explanation of benefits if services are denied

(PLEASE COMPLETE AND SIGN REVERSE SIDE)

Patient given Bill of Rights Date: _____ Signature: _____

Pregnancy Paper Work At Planparent Hood

JL Elias



Pregnancy Paper Work At Planparent Hood:

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