

Planned Parenthood of Indiana

Today's Date: ____/____/____ Account Number: _____

Gender: Male Female **Date of Birth:** ____/____/____ **Social Security Number:** ____-____-____

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ ST: _____ Zip: _____

May PPIN send you mail in a plain envelope? Yes No

Home Phone: (____)____-____ Can we call you at home? Yes No

Work Phone: (____)____-____ Can we call your work? Yes No

Cell Phone: (____)____-____ Can we call your cell? Yes No

Is it OK to say we are calling from Planned Parenthood? Yes No

If you answered **No** to any of the above questions, you must provide an alternate way to contact you:

Alternate Contact Name: _____

Address: _____

Phone: (____)____-____ City State Zip

Is this person also your Emergency Contact? Yes No If not, complete Emergency Contact Information.

Emergency Contact Name: _____

Address: _____

Phone: (____)____-____ City State Zip

Current Birth Control Method: _____ Desired Method: _____

Do you want to authorize someone to pick up your supplies for you? Yes No

Name(s): _____

Marital Status: Single Married Legally Separated Divorced Widowed

Race: Check all that apply Asian Black White American Indian/Alaska Native
 Native Hawaiian/Pacific Islander Other _____

Ethnicity: Hispanic? Yes No

Employment: Full-time Part-time Unemployed Not seeking work

Employer: _____

Highest School Grade Completed: _____ Are you a Student? If yes, Full-Time Student or Part-Time Student

Total **Weekly Household** Income before Taxes: \$_____ (Wages, Disability, and Social Security)

The # of People in Household Supported by this Income: _____

Your Number of Living Children: _____

Do you have Health Insurance or Medicaid? Yes No

Do you want us to bill your insurance for services provided to you today? Yes No

Policy Holder's Name: _____

Policy Holder's Date of Birth: ____/____/____ Policy Holder's Relationship to Patient: _____

If you would like us to bill your Insurance or Medicaid please present your card to the Front Desk Staff.

You will be responsible for any supplies or lab fees not covered by your insurance. Initials _____

I understand that information may be released from my medical record if I am having my services billed to an insurance company or other third party. *Signature:* _____