Planned Parenthood®
of Delaware

Demographic Information

Patient Name: ______________________________ DOB: _____________ Patient Number: ____________

Date: ___________________________________

Last Name: ______________________________ First Name: _________________________ Middle Initial: ______

Address:_______________________________________ Apartment/PO Box Number:_________________________

City: _________________________ State: _____ Zip: ________Employer: __________________________________

Home phone: (________)___________ Work phone:(__________)_____________

Cell phone: (________)___________ Personal Email: _____________@_____________

Emergency phone: (________)____________________ Name/relationship: ______________________________

We must have a way to contact you if your results are abnormal. How may we contact you? Check **all** that apply:
☐ Home phone ☐ Work phone ☐ Cell Phone ☐ Mail ☐ Mail anonymous ☐ Other ____________________

May we contact you for fundraising requests? Yes______ No______
May we use and disclose your protected health information for marketing purposes? Yes______ No______
Pharmacy Information: Pharmacy Name___________________________ Phone #___________________

Housing Status: ☐ Own ☐ Rent ☐ Live with Family Member ☐ Live with Non-Family Member ☐ Shelter ☐ Homeless ☐ Other __________

Marital Status: ☐Married/Civil Union ☐Divorced ☐Single ☐Separated ☐Widowed ☐Live-in Partner

Race: ☐American Indian/Alaskan ☐Asian Pacific ☐Black ☐White ☐Biracial ☐Other___________________
(please specify)

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Language**: ☐ English ☐ Spanish ☐Other____________________

Employment status: ☐Full time ☐Part time ☐Unemployed

Highest grade completed: ______ **Are you a student now**? _______ ☐Full time ☐Part time

Social Security #: ___________________ **Date of Birth**: _______________

Sex: ☐Male ☐Female ☐Other _______________________

Age at first pregnancy ________ Date of last pregnancy __________________
Number of pregnancies (not including this one, if currently pregnant) _________
# of miscarriages_______ # of stillbirths______ # of abortions______ # of live births______ # of living children_____

Payment Information:
Payment is expected at the time of service. We gladly accept cash, check, MasterCard or Visa
❒ I will pay the bill myself ❒ I have Medicaid ❒ I have Medicare ❒ I have private Health Insurance
❒ I have had Medicaid or a Medicaid HMO in the past 2 years. You may be eligible for a special funding program.
I certify that the above information is accurate and complete. If I am using Medicaid, Medicare or another insurance, I request any payment of health insurance benefits be made directly to Planned Parenthood of Delaware or its contracted vendors. I understand that I am responsible for the payment of any deductibles, co-payments, co-insurances or services not covered by insurance.

Signature:____ Date:______________________________

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