



**Planned Parenthood California Central Coast
Patient Registration Form**

*Planned Parenthood is committed to maintaining client confidentiality and quality health care. There are times when we discover a medical problem that requires immediate notification.
We MUST know how you can be reached!*

Last Name _____ First Name _____

Preferred Name _____ Preferred Pronoun (i.e. she/he/they) _____

Social Security Number _____ Date of Birth _____

Sex assigned at birth (circle one): Female Male

Address _____ City _____ State _____ Zip _____

Please give us a phone number where we can call you? _____

Do you have a 2nd phone number where we can call you? _____

Can we leave a message that Planned Parenthood Called? ___ Yes ___ No

If No, can we just leave a message that your doctor called? ___ Yes ___ No

If No, can we have a code name to use to leave a message? Code word _____

Racial Group (Please Check ALL that Applies)

___ American Indian or Alaska Native ___ Asian ___ Black/ African American

___ More than one race ___ Native Hawaiian or other Pacific Islander

___ White (Caucasian/Hispanic) ___ Other ___ Unknown

Do you need our staff to speak to you in a language other than English? ___ Yes ___ No

(If Yes circle one) Spanish Mixteco Tagalog Chinese Japanese Korean Vietnamese

Portuguese Other _____

Ethnic Group ___ Hispanic ___ Not Hispanic

Marital Status ___ Single ___ Married ___ Separated ___ Divorced ___ Life Partner

Emergency Contact Name _____ **PH#** _____

Where did you hear about us?

___ Friend/Relative ___ Referred by Another Medical Provider ___ Website

___ Health educator in community ___ Local Health fair ___ Other



Do you have Health Insurance? No Yes (If yes please take your insurance card to reception)

Are you homeless? Yes No

Are you a Migrant Worker Yes No

Family Size (include self, spouse, children): _____

What is your **monthly** income (if MARRIED include spouse's income) \$ _____

Consent for Treatment/ Authorization to Bill insurance

You are financially responsible for all services provided. As a courtesy, we will bill your insurance. Your insurance will reimburse based upon your coverage, eligibility, deductible or co-pays. By signing this form, you understand that you are financially responsible for your medical care and agree, understand, and will adhere to our financial policy.

I hereby consent to and authorize the administration of all treatments that may be considered advisable or necessary in the judgment of Planned Parenthood. I authorize Planned Parenthood to furnish a copy of this report to my insurance carrier. I hereby authorize the staff of Planned Parenthood to furnish information to insurance carriers or a third party review organization concerning my illness and treatments and I hereby assign Planned Parenthood all payments for medical services. A photocopy of this authorization is valid as the original.

I authorize payment of medical benefits to the clinic for medical services received at PPCCC.

I authorize PPCCC to provide any information necessary for laboratory services. I understand that I may receive a separate bill for any outside services.

I understand that suspicions of child abuse and neglect, statutory rape, domestic violence and sexual assault are required to be reported by state law.

I agree to accept mail regarding my account at address provided on the previous page, or to enroll in the PPCCC Patient Portal to receive electronic account information.

Signature

Date

Please return this form to the front desk. Thank you.