Planned Parenthood
Care. No matter what.
Planned Parenthood Mar Monte

Patient Information

Gender Inclusivity - While Planned Parenthood recognizes there are more than two genders, many agencies that fund our services do not. Due to this, please be aware that the legal name and gender you have listed on any applications for funding and your medical history must be used on documents pertaining to insurance and billing. If your chosen name or pronoun are different from these, note below. If you have any questions or concerns about this please let us know.

Last Name: _____

Legal First Name: _____

Chosen Name: (if different than legal name) _____

Date of Birth: _____

Cell/ Day Phone: _____

Home Phone: _____

Email Address: _____

We will send you an email with information about our secure patient portal.

Social Security Number: _____

Sex Assigned at Birth? ☐ Male ☐ Female ☐ Intersex

PPMM can communicate with me through: ☐ Email ☐ Text Message

Gender Identity? ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Genderqueer, non-binary ☐ Decline to State ☐ Additional category (please specify): _____

If we have to contact you by phone, should we say it's:
____Planned Parenthood ____Code Name: _____
____Doctor's Office

Chosen Pronoun: ☐ She/Her ☐ He/Him ☐ They/Them ☐ Additional category (please specify): _____

Address: _____

Apt #: _____ **City:** _____

State: _____ **Zip:** _____

Emergency Contact: _____

Relationship: _____

Phone: ( )

Preferred Pharmacy:

Statistical Information

The questions below are for statistical information only and your responses will remain completely confidential. We are required to ask these questions by one of the agencies that provides us funding.

What is your race?

_____ American Indian or Alaskan Native
_____ Asian
_____ Black or African American
_____ Decline to Specify
_____ Native Hawaiian or Other Pacific Islander
_____ Other Race
_____ White

Are you homeless or without a permanent residence (such as living with friends or an adult living with parents)?

_____ Yes _____ No

Do you have any physical or mental disabilities?

_____ Yes _____ No

How did you hear that Planned Parenthood offers the services you are here for today?

_____ A Planned Parenthood Health Educator or Peer Educator
_____ Online search (such as Google)
_____ Health Fair / Community Event
_____ Flyer / Poster
_____ Friend / Family

What language do you prefer to speak?

_____ English
_____ Spanish
_____ Other _____

Do you need our staff to speak to you in a language other than English?

Yes _____ No _____

Who is your Primary Care Provider/Clinic?

_____

Do you consider yourself to be Hispanic/Latina(o)?

_____ Yes
_____ No
_____ Decline to Specify

Are you a migrant worker? (Do you travel from one area to another in search of work?)

Yes _____ No _____

Insurance Information

Are you covered under any of the following:

_____ Cancer Detection Program
_____ FPACT
_____ Private Insurance
_____ Other _____
_____ Medi-Cal
_____ None

What is your family size?
(INCLUDE ONLY yourself, spouse, and/or children under 18) _____

What is the number of members in your household? _____

What is your monthly income before taxes?
(include spouse's income if married) _____

The information I have provided is true. I agree to pay the full price for services not covered by my health insurance or reimbursed by a third party. I understand that I am ultimately responsible to pay for services rendered.

Client Signature: _____ **Date:** _____