

REGISTRATION FORM

(Please Print)

Today's date:		When is your appointment?			
CLIENT INFORMATION					
Client's last name:		First:	MI:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.
				Marital status (circle one) Single / Mar / Div / Sep / Wid	
Social Security Number:			Birth date:		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male
May we contact you by: <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Email			<input type="checkbox"/> Do not contact me by mail/phone or email		
Email address:					
Mailing Address:		City:		State:	ZIP Code:
How did you hear about us? (please check one box):			<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Website <input type="checkbox"/> Advertisement <input type="checkbox"/> Outreach Event
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Are you covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If you are covered under your parents plan, can we bill for services you receive at Family Planning?			<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please bring a copy of your insurance card with you to your appointment.	
Do you have medical coupons?			<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please bring to your appointment.	
FINANCIAL PROGRAMS					
We have several programs that can help you with the costs of your healthcare. There are a few things we need to know to help you get started.					
Are you a US citizen or US National? <input type="checkbox"/> Yes <input type="checkbox"/> No		Where were you born?		City: _____ State: _____	
You will need one of the following: <i>Your Photo ID (Drivers License, School)</i> AND <i>Your Birth Certificate -OR- Passport -OR- Your Certificate of Naturalization</i>				Mother's Maiden Name: _____	
				Father's Name: _____	
		Are you working? <input type="checkbox"/> Yes <input type="checkbox"/> No			
MEDICAL NEED FOR FAMILY PLANNING SERVICES					
Male or Female Applicants:			Female Applicants:		
Do you intend to use a birth control method to prevent unintended pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you have any reason to believe you may be pregnant now? <input type="checkbox"/> Yes <input type="checkbox"/> No		
CONFIDENTIALITY					
FAMILY PLANNING STRIVES TO INSURE THAT ALL OF YOUR INFORMATION IS KEPT CONFIDENTIAL. WE WILL NOT RELEASE ANY INFORMATION TO ANYONE WITHOUT YOUR CONSENT. FAMILY PLANNING WILL NOT CONTACT YOU BY MAIL, PHONE OR EMAIL WITHOUT YOUR WRITTEN CONSENT.					
FAMILY PLANNING HAS MY PERMISSION TO CONTACT ME AS FOLLOWS:					
<input type="checkbox"/> MAIL <input type="checkbox"/> PHONE CELL Number: _____ Home: _____					
<input type="checkbox"/> Email Address: _____					
Signed:			Date:		