Planned Parenthood®
Care. No matter what.
Planned Parenthood Arizona, Inc.

PLACE PT LABEL HERE

PATIENT INFORMATION FORM

Last Name	First Name	Middle Initial	Name Used/Nickname:
Social Security Number -- --	**Date of Birth** (MM/DD/YYYY) / /	**Sex** ☐ Female ☐ Male	
Pronouns ☐she/her/hers ☐ he/him/his ☐they ☐other: ________________		**Gender Identity** ☐Female ☐Male ☐Genderqueer ☐ Other	
Address	**City and State**		**Zip Code**
Day Phone Number	**Alternate Phone Number**	**Email**	
We may need to contact you regarding your personal health information. How do you prefer we contact you? ☐ Mail ☐ Phone			
Emergency Contact Name	**Emergency Contact Phone Number**	**How did you hear about Planned Parenthood® Arizona?**	
Family Income $ ____________________________ ☐Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly		**Family Size** (# of people supported by your income)	

Race (check all that apply)	Ethnicity	Primary Language	Marital Status	Student Status
☐ African American or Black ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other: ____________________	☐Hispanic/Latino/Latina ☐Non-Hispanic	☐English ☐Spanish ☐Other ______________	☐Single ☐Married ☐ Significant Other ☐ Legally Separated ☐Divorced ☐Widowed	☐Full Time Student ☐Part Time Student ☐Not a Student

PERMISSION FORM FOR USE OF EMAIL, TEXT, AND RECORDED VOICE MESSAGES **I have read the permission form and agree to receive marketing communications.**	☐ I do not agree
Would you like information about Advanced Health Care Directives?	☐ Yes ☐ No
Under Title X of the Public Health Services Act funds are available for some services at no cost or discounted based on your family income and household size. Would you like to be considered for this program?	☐ Yes ☐ No

INSURANCE / AHCCCS INFORMATION

Policyholder Relationship to Patient: ☐ Self ☐ Parent ☐ Significant Other ☐ Spouse

Policyholder Last Name, First Name	Policyholder Social Security - -	Policyholder Date of Birth / /
Policyholder Address, City, State, & Zip ☐ same as patient	**Policyholder Phone Number**	**Policyholder Sex** ☐ Female ☐ Male
Plan Name	**Policy Number**	**Group Number**
Plan Address, City, State, & Zip	**Plan Contact Phone Number**	

SECONDARY INSURANCE / AHCCCS INFORMATION

Policyholder Relationship to Patient: ☐ Self ☐ Parent ☐ Significant Other ☐ Spouse

Policyholder Last Name, First Name	Policyholder Social Security - -	Policyholder Date of Birth / /
Policyholder Address, City, State, & Zip ☐ same as patient	**Policyholder Phone Number**	**Policyholder Sex** ☐ Female ☐ Male
Plan Name	**Policy Number**	**Group Number**
Plan Address, City, State, & Zip	**Plan Contact Phone Number**	

I acknowledge that all of the above information is true and correct and that it has been furnished to this office with full knowledge. I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted and I will be bound by the signature as though I personally signed the claim. I also authorize the release of any medical information necessary. **I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES.** If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedures.

_______________________________________ _______________________________

Signature of Patient Date

Planned Parenthood®
Care. No matter what.
Planned Parenthood Arizona, Inc.

PLACE PT LABEL HERE

PATIENT INFORMATION FORM

INSURANCE WAIVER

Patients electing to pay out-of-pocket for services instead of using their insurance should sign and date the acknowledgement below for each date of service

I hereby waive the right to use my insurance coverage for all Planned Parenthood Arizona services provided on this date of service. I acknowledge I will not be able to obtain reimbursement from my insurance company for these charges.

Date of Service: ___________________________ Patient Signature: ___________________________

Date of Service: ___________________________ Patient Signature: ___________________________

Date of Service: ___________________________ Patient Signature: ___________________________

Office Use Only

TITLE X VERIFICATION/ELIGILBILITY

Title X eligibility must be performed every six months, along with a PIF update.

Title X Excluded Visit: ❑ Yes ❑ No **IF "NO" complete the following:**

Title X Program Eligible: ❑ Yes ❑ No

Percentage of Poverty:______________________________ Slide % ____________________________

If Client income is less than 100% of FPL, client was encouraged to follow up with AHCCS / DES ❑ Yes ❑ No

Staff Signature: **Date:**