Planned Parenthood®
Care. No matter what.
Greater Memphis Region

Chart Number _____

Today's Date_____

Last name_____First Name _____

SSN_____DOB _____ Sex_____Preferred Pronoun ❑ he ❑ she

Mailing Address_____City_____

State_____Zip_____County _____

Cell Phone_____Alternate Phone _____

Preferred Pharmacy: Name_____Pharmacy Phone Number _____

Race: Select all that apply ❑ White ❑ Black ❑ Native Hawaiian ❑ American Indian ❑ Alaskan Native ❑ Asian ❑ Pacific Islander

Preferred Language:_____ Ethnicity: ❑ Hispanic ❑ Non-Hispanic

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Single w/ Partner ❑ Domestic Partnership

Education Level: ❑ 8th grade or less ❑ 9-12 grade/no diploma ❑ High School Diploma
❑ Some College/No Degree ❑ Associates Degree ❑ Bachelors Degree ❑ Post Grad Degree

Occupation:_____Employer: _____

Do you have health insurance? ❑ Yes ❑ No If, yes ❑ Public/Government or ❑ Private/Commercial

Email Address (optional): _____
NOTE: We do not use email to notify you of test results or other protected health information.

PATIENT COMMUNICATION: MUST BE COMPLETED
Planned Parenthood must contact you in certain situations. We want to protect your privacy and confidentiality.

If it is necessary to reach you with abnormal test results or information about your financial responsibility,
What do you want us to say when calling your cell number? ❑ Planned Parenthood ❑ Dr. Office ❑ Heather
What do you want us to say if we call your alternate number? ❑ Planned Parenthood ❑ Dr. Office ❑ Heather
May we mail you letters at the mailing address you've given us? ❑ Yes ❑ No
May we put Planned Parenthood's return address on the envelope (street, city, state and zip ONLY)? ❑ Yes ❑ No
If you DO NOT want to be contacted at any of your phone numbers or mailing address about abnormal test results:
Who can we contact about abnormal test results?_____Relationship to you:_____

His/her address:_____His/her phone:_____
We may send a certified letter to the mailing address you have given if that is the ONLY way we can notify you of abnormal test results.

Emergency Contact: Who should we contact in case of emergency ONLY? Name: _____

Relationship:_____Phone: _____

Insurance Policy Information: Please present current insurance card for copying and complete the following:

Primary Insurance Company:_____

Policy #_____Group # _____

Policy Holder Name (if not self)_____Relationship to you _____

Policy Holder DOB _____

Screening for Discounted Services
PPGMR offers some services at discounted rates. To see if you qualify, we need proof of the following information:

Total gross household income:_____How many people are supported by this income? _____
You do not have to disclose your income if you choose not to. This is voluntary.

❑ I have received and read a copy of the PPGMR Financial Responsibility Statement and agree to its terms.

Signature_____Date _____