

**Planned Parenthood of Southern New Jersey
FEMALE REGISTRATION FORM**

Today's date:	Chart Number:
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PATIENT INFORMATION (PLEASE PRINT)

Patient's last name:	First:	Middle:	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Living With Partner
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Hispanic Origin: <input type="checkbox"/> Yes <input type="checkbox"/> No	Race: <input type="checkbox"/> Am Indian/AK native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Pac Is/HI native <input type="checkbox"/> Other <input type="checkbox"/> Unknown	Preferred Language:	Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Street address:	City/State:	ZIP Code:
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Apt. #:	Home Phone ()	Cell Phone ()
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County:	May we identify ourselves as Planned Parenthood if we call/write? <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Sec No.:
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How were you referred to this clinic (please check one box): Family Friend Close to home/work Yellow Pages Dr. Other

How many times have you been pregnant? Total number of Births:_____ Miscarriages:_____ Abortions:_____

INCOME/INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

What is your household income? \$	Is this income? <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
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Number of people who depend on this income?	Number of Children?
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How will you pay for today's visit? <input type="checkbox"/> Health Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Self-Pay	Are you currently a student? <input type="checkbox"/> Yes <input type="checkbox"/> No Highest grade you have completed?_____	If so, what type? <input type="checkbox"/> Jr High <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Grad School <input type="checkbox"/> Other
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IN CASE OF EMERGENCY (REQUIRED)

Name/Address of local friend or relative:	Relationship to you:	Home phone no.: ()	Work phone no.: ()
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SIGNATURE (REQUIRED)

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to PPSNJ. I understand that I am financially responsible for any balance. I also authorize PPSNJ or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date
PPSNJ Staff Signature	Date

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