FAMILY PLANNING ENCOUNTER

Date ___________________

Preferred Name____**Birthdate:**_______________

Legal Name____**SS#**___________________
Last First M.I.

Preferred Pronoun: He She They Other

Address____**City**_________________**ST**______**Zip**__________

Home Phone_____________________ **Cell Phone** ___________________ **E-mail** _________________________

Does your family know you receive services from Family Planning? NO Yes Who?________________
May we contact you by: Phone______ Mail______ Email______ No Contact ______
***If no contact list an alternate contact person phone & address where you can be reached.**
Name ________________________________Relationship ___________ Phone___________________________
Alternate Address ____
List address where you want to receive billing statements ____

Emergency Contact: _____________________ Relationship ___________ Phone ______________________

Relationship Status (circle one) Single Married Divorced Separated Widowed Partner

 # OF PREGNANCIES_________ **# OF BIRTHS**_________ **# OF LIVING CHILDREN**_________

Employment Status (circle one) Employed Unemployed Not in the work force

Your Income __________________ Circle One: Weekly Bi-Weekly Monthly Yearly
Spouse's Income _____________ Circle One: Weekly Bi-Weekly Monthly Yearly
Parents Income (teens only: if parents know you are here) ________________________________
How many people are supported on the above noted incomes? ____________________

Do you have Medicaid, All Kids or Medicare? Yes No

Do you have Health Insurance? Yes No Unknown
NAME OF INSURANCE: ____
If you are under your parent's insurance may we bill the insurance company? Yes No
(If yes, your parents will receive a notice from the insurance company of the services you have today.)

Primary Language: English Spanish Other____________ Do you require an Interpreter? Yes No
Hispanic Ethnicity: Yes No
RACE(circle all that apply) White Black Am. Indian/AK Native Asian Native Hawaiian/Pac. Is. Unknown/Not Reported
Gender Assigned at Birth: Male/Female

Gender Identity (circle one): Male/Female/Transgender MTF/Transgender FTM/Decline/Other:________

Sexual Orientation (circle all that apply): Lesbian/Gay/ Straight/ Bi-sexual/ Don't Know /Decline/Other:_______

WHO REFERRED YOU TO THIS CLINIC?
Other Family Planning Clinic Hospital/Health Agency Private Doctor Social/Church Agency School Equality Clinic Flyer
Other Patient Family/Friend Media/Phonebook/Internet Hotline WIC IBCCP Local DHS Office

Do you have diabetes? **YES NO**
Are you homeless or live in homeless shelter? **YES NO**
Do you have a developmental disability? **YES NO**
Are you a veteran? **YES NO**
Do you use tobacco? **YES NO**