

**PPAU PATIENT REGISTRATION**

Date \_\_\_\_\_

Name \_\_\_\_\_  
FIRST MIDDLE LAST Social Security Number

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_ Male \_\_\_ Female  
Month/Day/Year

Mailing Address \_\_\_\_\_  
STREET CITY STATE ZIP

Contact Phone # \_\_\_\_\_ Other Phone # \_\_\_\_\_

Hispanic/Latino Yes \_\_\_ No \_\_\_ Translation services needed Yes \_\_\_ No \_\_\_

**Circle One** Caucasian/White African American/Black Asian American Ind Pacific Is Alaskan  
More than one race Other \_\_\_\_\_

How may we contact you? Mail \_\_\_\_\_ Phone \_\_\_\_\_ Both \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
First Last Relationship

Yearly Income \_\_\_\_\_ Number supported by income \_\_\_\_\_

How did you hear about us? Yellow Pages Advertisement Radio Education Presentation Friend/Family member

Other:

I certify that to the best of my knowledge, the above information is true. I request that a person authorized by Planned Parenthood provide appropriate evaluation, testing and treatment.  
I assign my insurance benefits to PPAU. I agree to pay for all charges not paid by the insurance company. I authorize PPAU to release all or part of the patient's record to any person or organization liable for payment.

Patient Signature: \_\_\_\_\_

**If you currently have health insurance please show card to receptionist**