

PLANNED PARENTHOOD OF CENTRAL OKLAHOMA
Patient Information

Office use: EDM MWC NOR OKC SOC

To help us learn more about you, please complete the following:
 (Please print clearly)

(Please circle one)

Last Name:	First Name:	M.I.	Mr.
Address:			Mrs.
City:	State:	Zip Code:	Ms.
Home Phone:	Work Phone:		
Date of Birth:	Social Security Number:		
Occupation:	Employer:		

(Please circle one)

Marital Status: Married Single Divorced	If married, spouse's name:	Number in Household:
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(Please circle one)

How did you hear about us?	Coupon	Drive by	Family Member	Friend	Newspaper	Phone Book
	Health Dept	Radio	Movie Theater	T.V.	Outdoor Ad	Shopping Mall Ad

(Please circle one)

Are you a student?	Yes	No
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(Please circle one)

Is it okay to contact you by phone?	Yes	No	Mail?	Yes	No
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(Please circle one)

Would you like to be placed on our mailing list for our newsletter and other mailings?	Yes	No
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Contraceptive Method (circle one)	Ethnicity (circle one)	Education (circle one)	Gross Household Income (circle one)	Payment Method (circle one)
Depo Provera	Asian	8 th Grade or less	0 - \$5000	Cash/Check
Pills	Native American	Some High School (1-3 yrs)	\$5001 - \$10,000	Credit Card
IUD	African American	High School/GED Equivalent	\$10,001 - \$15,000	Medicaid
Diaphragm/Cervical Cap	Caucasian/White	Some College	\$15,001 - \$20,000	Blue Cross/Blue Shield
Condom/Foam	Hispanic	College Graduate	\$20,001 - \$25,000	
Sterilization	Other:	Post Graduate	\$25,001 - \$30,000	
Implanon		Trade/Tech School	\$30,001 - \$35,000	
Partner's Method			\$35,001 - \$40,000	
Patch			\$40,001 - \$45,000	
Ring			\$45,001 - \$50,000	
Fertility Awareness Method			\$50,001 - \$55,000	
None			\$55,001 - \$60,000	
			\$60,001 +	

If you would like us to file a claim with your private insurance company, please complete the following:

Insurance name: _____	Insured's ID Number: _____
Insurance address: _____	Group Number: _____
Insured's name if other than the patient: _____	Insured's date of birth: _____

I authorize the release of any medical or other information necessary to process a claim with my insurance company. I authorize payment of medical benefits to the attending physician or service provider. I understand that my services must be paid in full prior to the claim being filed.

Signed: _____	Date: _____
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