Planned Parenthood
Care. No matter what.
Planned Parenthood Arizona, Inc.

PATIENT INFORMATION FORM

PLACE PT LABEL HERE

Last Name	First Name	Middle Initial	Name Used/Nickname:
Social Security Number -- --	Date of Birth (MM/DD/YYYY) / /	Birth Sex ☐ Female ☐ Male ☐ Undifferentiated	
Pronouns ☐She/Her/Hers ☐He/Him/His ☐They ☐Other: ________________		Gender Identity ☐Female ☐Male ☐Transgender Female ☐Transgender Male ☐Genderqueer ☐ Other	
Address	Apartment	City, State	Zip Code
Cell Phone Number*	Alternate Phone Number	Email	

**You will receive automated text notifications for appointments at your cell phone number.*

If we need to contact your about your visit, is it okay to say we are calling from Planned Parenthood?
☐ Yes ☐ No – identify as Dr. Office

Emergency Contact Name	Emergency Contact Phone Number

Family Income $________________ ☐**Weekly** ☐**BiWeekly** ☐**Monthly** ☐**Annually**

Family Size (# of people supported by your income)

Race (check all that apply)	Ethnicity / Primary Language	Marital Status	Student Status
☐ African American or Black ☐ American Indian or Alaska Native ☐ Asian ☐ Native American ☐ Native Hawaiian or Pacific Islander ☐ White	**Ethnicity** ☐Hispanic/Latino/Latina ☐Non-Hispanic **Primary Language** ☐English ☐Spanish ☐Other	☐Single ☐Married ☐ Significant Other Partner ☐Domestic ☐Legally Separated ☐Divorced ☐Widowed ☐Polygamous	☐Full Time Student ☐Part Time Student ☐Not a Student

PERMISSION FORM FOR USE OF EMAIL, TEXT, AND RECORDED VOICE MESSAGES **I have read the permission form and agree to receive marketing communications.**	**Opt Out of Communications** ☐ I do not agree
Would you like information about Advanced Health Care Directives?	☐ Yes ☐ No

INSURANCE / AHCCCS INFORMATION

Policyholder Relationship to Patient: ☐ Self ☐ Parent ☐ Significant Other ☐ Spouse

Policyholder Last Name, First Name	Policyholder Social Security - -	Policyholder Date of Birth / /
Policyholder Address, City, State, & Zip ☐ same as patient	Policyholder Phone Number	Policyholder Sex ☐ Female ☐ Male
Plan Name	Policy Number	Group Number
Plan Address, City, State, & Zip	Plan Contact Phone Number	

SECONDARY INSURANCE / AHCCCS INFORMATION

Policyholder Relationship to Patient: ☐ Self ☐ Parent ☐ Significant Other ☐ Spouse

Policyholder Last Name, First Name	Policy holder Social Security - -	Policy holder Date of Birth / /
Policyholder Address, City, State, & Zip ☐ same as patient	Policyholder Phone Number	Policyholder Sex ☐ Female ☐ Male
Plan Name	Policy Number	Group Number
Plan Address, City, State, & Zip	Plan Contact Phone Number	

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I acknowledge that all of the information is true and correct and that it has been furnished to this office with full knowledge. I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted and I will be bound by the signature as though I personally signed the claim. I also authorize the release of any medical information necessary. **I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES.**

______________ I authorize PPAZ to bill other primary insurance given by AHCCCS (AHCCCS will notify PPAZ of other insurance coverage on file).
Patient Initials

I acknowledge the laboratory services may not be considered eligible for benefits (e.g., services may be determined to not be medically necessary, may be deemed as out of network, and/or may be applied towards my deductible) by my health insurance and/or co-insurance provider. I understand that my health insurance coverage may have certain restrictions and limitations, such as prior-authorization requirements and non-covered benefit guidelines.

PPAZ will select a laboratory for you based on our laboratory insurance guidelines and you will be financially responsible for any non-covered services.

Patient Signature: ______________________________ Date: ____________________

INSURANCE WAIVER

Patients electing to pay out-of-pocket for services instead of using their insurance should sign and date the acknowledgement below for each date of service

I hereby waive the right to use my insurance coverage for all Planned Parenthood Arizona services provided on this date of service. I acknowledge I will not be able to obtain reimbursement from my insurance company for these charges.

Date of Service: ___________ Patient Signature: ____________________

Date of Service: ___________ Patient Signature: ____________________

Date of Service: ___________ Patient Signature: ____________________