OFFICE OF MATERNAL, CHILD AND FAMILY HEALTH
FAMILY PLANNING PROGRAM

# FAMILY PLANNING PROGRAM BASIC DATA

Social Security Number _____ Telephone No. _____

Name _____ County _____

Address _____ City _____ State ___ Zip ___

Sex F ___ M ___ Race ___ Birth date _____ Age ___ Last Grade of School Completed ___

Medical Insurance (Name of company or Medicaid) _____

Permission to Contact: ☐ Phone ☐ Mail ☐ Other: _____ (list)
☐ Do Not Contact Directly (Must specify alternate contact):

Alternate Contact: Name _____ Relationship _____
Address _____ Telephone No. _____

## CONSENT FOR SERVICES - ASSURANCE OF CONFIDENTIALITY

- I understand medical services may include appropriate laboratory testing, physical examination, pap smear and pelvic examination.
- I voluntarily agree to participate in the Family Planning Program and grant permission to have such physical examination, diagnostic and/or treatment procedures as may be deemed necessary in collaboration with authorized personnel of said health facility.
- I have been informed that this clinic assures patient confidentiality and provides safeguards against the invasion of personal privacy, as required by the Privacy Act of 1974 and Health Information, Portability and Accountability Act (HIPAA) regulations. All information which may be identified with me will be considered privileged and confidentiality will be maintained.

| Signature | Date | Signature of Witness |
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## ANNUAL SIGNATURE UPDATES

| Signature | Date | Signature of Witness |
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ALL CLINICAL SERVICES ARE PROVIDED ON A CONFIDENTIAL AND NON-DISCRIMINATORY BASIS.