Patient Registration

Last Name ______ First Name ______ MI ______ Preferred Name ______ Date of Birth ____/____/____

Mailing Address ____
Street Number Street Name Apt No. City State Zip Code

Phone ______________________ ❑ Cell   Social Security Number (optional) ____-____-____

Gender Identity ❑ Male ❑ Female ❑ Transman ❑ Transwoman ❑ Genderqueer/Gender Nonconforming ❑ ____________

Sex Assigned at Birth ❑ M ❑ F   Preferred Pronouns ❑ she/her/hers ❑ he/him/his ❑ they/them/theirs ❑ other ________

Do you have medical insurance? ❑ Yes ❑ No   Are you planning to use your insurance today? ❑ Yes ❑No   If no, why?________

If you are using insurance today, what type? ❑ Medicaid ❑ Other ______________________ **Please present card**

Insurance Policy Holder ______ Relationship to you ______ Email Address ______

How can we contact you? Check all that apply ❑ Phone ❑ Mail ❑ Email ❑ Text   Is it ok to say family planning when calling? ❑ Yes ❑ No

Emergency Contact Person (we would not discuss the reason we are calling) ______ Phone ______ Relationship to you ______

Assignment and Release

I have coverage and assign directly to Maine Family Planning all medical benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature on all of my insurance submissions. I also authorize Maine Family Planning to release my health care information, to the extent necessary, to my insurance carriers and their reviewers of others paying for this care. This authorization is effective until final payment or 30 months (whichever is sooner).

I understand that in most cases the policy holder will be sent information by the insurance plan about the services I receive at this visit.

For Statistical Purposes

How did you hear about us? ❑ Hospital ❑ Other Medical Provider ❑ Friend/Family ❑ Internet ❑ Other ____________

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Partnered ❑ Separated

Are we your primary source of healthcare? ❑ Yes ❑ No   If no, do you have a PCP? ❑ No ❑ Yes Name ____________

Race: Check all that apply ❑ White ❑ Black ❑ American Indian/Alaskan ❑ Asian ❑ Hawaiian/Pacific Islander ❑ Other ______

Ethnicity: Are you Hispanic? ❑ Yes ❑ No   Primary Language: ____________   Do you need an interpreter? ❑ Yes ❑ No

Education: Highest year completed? ______ Grade 0-12 ______ College   Ancestry: Example: French, Irish, etc.________

Acknowledgment of Fee Collection Policy

- I agree to pay any insurance co-pays at the time of service. I acknowledge that I am responsible for charges not covered by insurance.
- I understand that payment is due at time of service in order to participate in the sliding fee discount program.
- I understand that any account balance that is older than 90 days will be considered for collections.
- **I understand that all lab testing is sent to Cytocheck/NorDx . They will bill my insurance/MaineCare/Medicare. If there is any amount remaining after insurance processing (or if I am a self pay) and I choose to have elective testing, I will be billed directly by Cytocheck/NorDx and this is my responsibility.**

Consent to Obtain Medication History

❑ I give my permission to obtain my medication history from my pharmacy, health plans and other healthcare providers

❑ I do not give my permission to obtain this information at this time

Patient Signature ______________________ **Today's Date** ______

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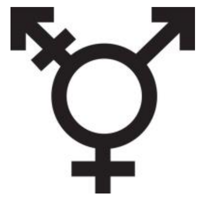

ASSIGNMENT AND RELEASE FOR OPEN DOOR HEALTH CARE

If you have medical insurance, please review and sign the following statement:

- My signature below authorizes Maine Family Planning to bill my insurance and receive payment from them for services given to me by Maine Family Planning.
- I understand that I am financially responsible for all charges not paid by insurance.
- I authorize the use of this signature on all my insurance submissions.
- I authorize the Maine Family Planning to release my health care information, to the extent necessary, to my insurance carriers and their reviewers or others paying for this care.
- **Charges for the labwork ordered by us will be billed by the lab to my private insurance, Medicaid/Medicare but if there is a remaining amount after insurance processing, I will be billed directly by the lab and that I am responsible for these charges.**
- I agree to pay any insurance co-pays at the time of service. I acknowledge that I am responsible for deductibles, coinsurance and charges not covered by insurance and those charges must be paid in full within 30 days or by my next appointment, whichever is sooner.
- I understand that for Medicaid, Medicare or Private Insurance to be billed, I **MUST** present a current insurance card at every visit.

_____ Initials

- Name of Policy Holder ____
- Relationship to Policy Holder ___________________________________

If you don't have medical insurance:

- I understand that payment for services at Maine Family Planning is due in full at time of service.
- **I understand that all lab orders can be sent to a lab of my choice and I will be billed directly by them for any testing and that I am responsible for those charges.**

_____ Initials

Everyone, please sign below:

Acknowledgement of receipt of Notice of Health Information Privacy Policies

- I hereby acknowledge that I have been given/offered the Maine Family Planning NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES.
- (Optional): I request that the following covered entities not have access to my private health care information without my written consent:

____

Signature: ____ Print Name: ____

Date: _____/_____/______

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Health History- Please complete and bring with you unless you do your history on your portal.

Name: ______________________ ***Date of Birth:***______________________

- Which pharmacy do you usually use for prescriptions? ______________________ Location?______________________
- Do you have another health care provider besides us? ❒ no ❒ If yes, who: ______________________

Medication allergies: ❒ no known med allergies	Med allergy # 1	Med allergy # 2	Med allergy # 3	Med allergy # 4	Med allergy # 5
Reaction to that medication:					
Other allergies:					

- What medications do you take regularly?

Medication/vitamin/supplement	Dose/strength (ie mg/pill)	How many times a day

Vaccinations

- **HPV vaccine** (Gardasil) for people under 45 yrs old

❒ All done ❒ had part of series ❒ have not had ❒ don't know ❒ might be interested

Family History: Who in your family has any of these problems and at what age did they get it if you know.

	Mo	Fa	Sis	Bro	Kids		Mo	Fa	Sis	Bro	Kids
Has no health problems	Age	Age	Age	Age	Age	Bleeding too easily	Age	Age	Age	Age	Age
Blood clotting disorder	Age	Age	Age	Age	Age	Cancer: type	Age	Age	Age	Age	Age

About you, your family, your life

We know some of these are very personal. You don't have to answer them if you are uncomfortable doing so.

Tobacco use-ever ❒ Smoker ❒ chewer? ❒ now ❒ past ❒ never If now, how much?_____ For how long?_________
Want help quitting? ❒ yes ❒ no
What sex were you assigned at birth? .... ❒ female ❒ male
What is your current gender identity? ....❒ female ❒ male ❒ Transwoman/transfemale/F-M
❒ Transman/trans male/F-M ❒ Genderqueer/gender non-conforming ❒ Intersex ❒ other: ______________
By what name would you like to be called? ______________________
Personal pronouns to describe yourself: ❒ she, her, hers ❒ he, him, his ❒ they, them, theirs Other: ____________
Your occupation______________________
In school now? ❒ yes ❒ no Highest grade completed ____
Are you: ❒ single ❒ married ❒ divorced ❒ separated ❒ widowed ❒ with a domestic partner
Number of children: ______ Ages: ______________
Whom do you live with? ❒ parents ❒ partner /spouse ❒ at school ❒ friends ❒ on your own ❒ your kids
❒ couch surfing ❒ in a shelter ❒ homeless ❒ other, __________
Interests/Hobbies:______________________
Life going well in general for you? .... ❒ yes ❒ no
Do you need any help from us in finding help or counseling for any problems or issues? ❒ yes ❒ no
Usual alcohol use _______ drinks a day ______ drinks a week

About your sexual history

Are you attracted to: (check all that apply) ❒ men ❒ women ❒ M-F ❒ F-M ❒ other______________

How do you describe your sexual orientation? ❒ Straight ❒ Gay/Lesbian ❒ Bisexual ❒ Asexual ❒ Other

Ever had sex? ❒ no ❒ yes , If yes, how many sexual partners have you ever had? _______

Were they ❒ male ❒ female ❒ M-F transgender ❒ F-M transgender ❒ other

Teens under 18… About your parents…

If you are having sex, do they know? ....❒ no ❒ yes

Do they know you are coming to clinic? ....❒ no ❒ yes

Can you talk to them about personal things in your life? ....❒ no ❒ yes

Contraception

What if, anything, are you using or doing to prevent pregnancy when you have sex?

❒ I am on a birth control method (type)_________________

❒ my partner uses birth control ❒ condoms ❒ withdrawal ❒ tubal ligation (tubes tied) ❒ vasectomy

❒ trying for pregnancy ❒ not using anything ❒ my partners have the same type of genitals as I do

❒ not having sex

Interested in a different birth control? ❒ No ❒ Maybe ❒ Yes, I want__________________________

Health History: **Please check off any of these that apply to you now or in the past.**

Headaches: ❒ frequent ❒ severe ❒ migraines ❒ Headaches with sparkles, spots or vision changes ❒ Epilepsy/seizures	❒ Eating disorder ❒ Significant weight ❒ gain ❒ loss
❒ Diabetes ❒ Cancer, type: ________________ when? ❒ Thyroid lump/enlargement or ❒ overactive ❒ underactive thyroid	**About risks/concerns- have you:** ❒ Had sex for money drugs or safety ❒ Had sex with someone with HIV/AIDS ❒ hepatitis B/C ❒ Substance abuse problems ❒ alcohol ❒ other
❒ Heart attack ❒ murmur ❒ other heart problems ❒ High blood pressure ❒ high cholesterol ❒ Bleeding disorder ❒ blood clotting disorder (not related to periods) ❒ Blood clot in ❒ lung ❒ leg ❒ brain/stroke	❒ Shared needles ❒ Had a partner who did ❒ Been forced to have sex or sexually abused? If yes, is this still affecting you now? ❒ Yes ❒ No **People assigned as female at birth**
❒ Asthma or other lung problems ❒ Stomach/intestinal problems ❒ gall bladder problems ❒ Hepatitis or other liver problems	❒ Breast cancer ❒ Fibroids/uterine growths ❒ frequent vaginal infections ❒ Have problems with pelvic exams
❒ Bladder infec/UTI/ other bladder/kidney probs ❒ incontinence ❒ Chlamydia ❒ gonorrhea ❒ genital warts/HPV ❒ Herpes ❒ syphilis ❒ HIV/AIDS	❒ Chronic pelvic pain ❒ endometriosis ❒ Ovarian: ❒ cysts ❒ ovarian cancer ❒ PCOS (polycystic ovaries) ❒ other problems with ovaries
People assigned as male at birth: ❒ NGU (infection of urethra) ❒ Prostate problems	❒ Pelvic infection/PID ❒ toxic shock ❒ Infertility/problems getting pregnant
Mental health problems: ❒ anxiety disorder ❒ depression ❒ bipolar ❒ other mental health probs: _________________ ❒ tried or seriously considered suicide ❒ recently ❒ in past	Other serious injuries, illnesses: ____________________________ ❒ None of these above items apply to me

Surgeries: ____ ❒ none

People assigned as female at birth

First day of your last period	Your age at your first period	# of Pregnancies	# of Births	# of Miscarriages	# of Abortions	# of Living Children	Date when last pregnancy ended

Date of last pap test: __________ It was ❒ normal ❒ abnormal.

Have you ever had any other abnormal pap tests? ❒ no ❒ yes, when ________?

Now breast feeding? ❒ no ❒ yes If menopausal, when was your last period? __________