Pathway Health Clinic Client Infc ation Sheet

Client #______________ ______

Legal Name ____ Maiden Name ____________ Preferred ________________________

Last First Mi

Gender: F M FTM MTF Preferred Pronouns ____________________________

Address ____________________________ City ________________ State _______ Zip __________ County ________________

Do you live with your parents? _______________ Do they know you are a client here? ________________________________

Billing address same as above? _____Yes ____ No If no, please provide ____

(St.) (City) (State) (Zip)

Date of Birth ______________________ Social Security # __________________________ (optional)

Cell phone #________________________ Home phone # _________________________

Email address ____ May we email **billing** statements to you? ____Yes ___ No

How may we contact you with test results? _____ Email _____mail ______ phone _______anonymous mail

Current Birth Control Method ___________ # of pregnancies___________ # of births__________ # of children ___________

Password: _____________ **You make up this code**, it can be a number or word; we use it to verify identification when you phone in for medical information.

Marital Status: ___Married
___Single
___Divorced
___Widowed
___Civil Union

Race: ___ White
___Black
___Asian
___Native Hawaiian
___Indian/Alaskan
___Pacific Islander
___Hispanic
___Native American
___Other
___Unknown

Primary Language: English, Spanish, or Other ____________ Limited English? ____ Yes ____ No

___By checking here, I permit Pathway Health Clinic to call and/or leave a message on the phone numbers listed above.

___By checking here, I permit Pathway Health Clinic to mail me billing statements.

___ I understand Pathway Health Clinic will send an anonymous letter to the above address, if I do not reply to messages left on my phone #, or the phone # is no longer in service (Sent only if your health is at risk).

Anyone else we may call with confidential info? ___Yes ___ No Who/relationship? ____________________Phone # _______________

Who Told You About Us? Please check

____ Another Family Planning Clinic
____ Another Patient
____Dept of Human Services
____ Doctor or Clinic
____Facebook
____Other (define)____________________
____ Family member
____Friend
____Health Dept
____Horizons
____Hospital
____ Instagram
____Newspaper
____Radio
____School
____Social Agency
____ Stall Readers
____Telephone book
____TV
___Twitter
___Website

____ ___________________________

Signature of client (confirming this information) Date