Pathway Health Clinic Client Information 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 _____

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.

Race: ___ White ___Pacific Islander ___Native Hawaiian ___ Other
___ Black ___Hispanic ___ Indian/Alaskan ___ Unknown
___Asian ___Native American

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

____ Media/internet/phone book ____ Family/Friend ____ Another patient _____ Social Agency
____ Another Family Planning Clinic ____ DHS ____ Private Doctor
____ School ____ Hospital/Clinic ____ Stall Readers at _____
(Where)

_____ _____
Signature of client (confirming this information) Date