MIDLAND COUNTY HEALTH DEPARTMENT
FAMILY PLANNING/CD CLINICS
CONFIDENTIAL PERSONAL INFORMATION

Name:______________________________ DOB:__________ Age: _____ Client ID# ________

Address: ____ SS#________________

Change ofAddress:____

Please list any other names you may have used at the Health Department.______________

I have read and verify that the above information is correct. Initial____________

Circle Marital Status: Never Married, Married, Widowed, Divorced, Separated

What is your Ethnicity? Circle one: Hispanic, Non-Hispanic

What is your Race? Circle one: White, American Indian, African American, Alaskan Native, Asian, Native Hawaiian, or Pacific Islander

What is your preferred language? ____________________

CONTACT INFORMATION:

It may be necessary to contact you if a test result indicates a potential or serious health risk or to cancel/reschedule an appointment. Check ***all*** acceptable ways the clinic may use to contact you. *You must pick at least one way to be contacted*. If we are unable to contact you by your preferred method, you will be mailed information in a plain envelope.

_____ OK to call or leave a message at: Cell____________________Other_____________

_____OK to be contacted by e-mail. Email Address: ____________________

_____ OK to say Health Department is calling.

Sign up for the patient portal to make appointments, receive appointment reminders, send messages and access your health information. Email Address:________________________________

HEALTH INSURANCE INFORMATION:

Do you have Medicaid? Circle one: Yes, No, Unknown

Do you have any other insurance besides Medicaid? Circle one: Yes, No, Unknown

If we bill your parent's insurance, they will receive a statement for today's family planning services.
Is this okay? Circle One: Yes, No, Unknown

FEE INFORMATION: All services are based on sliding fee scale.

PLEASE FILL OUT THE FOLLOWING PORTION (A) OR (B)BASED ON AGE.

(A) Under 18:

Are both your mother and father and/or guardian aware of your receiving services here? Circle one: Yes, No

If **YES**, what is the family/household total income before taxes (gross)? Circle week or month or year $
______

How many people, including yourself, are supported by this income? ______

If **NO**, what is your income from allowance, part time job, etc.? $____________________

(B) Ages 18 and Over- Do NOT Include Parent's Income:

What is the family/household total income before taxes (Gross)? Circle week or month or year
$____________

How many people, including yourself, are supported by this income? ______

(Household income includes spouse or partner. If you are not employed, give your spouse/partner income)

I verify that the above information is accurate:____

Client Signature **Date**

Date	$ Per Year	% to Pay	Initials

The information on this form has been reviewed and updated in PM by______________