

FAMILY PLANNING HEALTH SERVICES, INC.

CLIENT # _____

Name _____
Legal First MI Last Maiden Nickname

Address _____
Street/PO Box City State Zip Code County

How can we send mail? Plain envelope No

Home Phone _____ Work Phone _____ Cell Phone _____ Can we call you? At home At work Cell Phone

Can we say we are calling from Family Planning? at home at work cell phone just ask for me answering machine all

Alternate mailing Address (school breaks/summer/other) _____ From / / to / / Phone _____
MM/YY MM/YY

Date of Birth _____ BORN IN WISCONSIN? YES NO Age _____ Social Security # _____

Do you have a family physician? YES NO Do you have a family dentist? YES NO Do you have dental insurance? YES NO

Ethnicity (circle one): Hispanic Non-Hispanic	Race (circle one) Asian African Am Hawaiian/Pacific Islander Native Am. White Other Mixed
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The following information is required to be eligible for discounts:

Hours worked per week _____ Hourly wage _____

If not paid hourly (i.e. self-employed/commission), check here , and your net income is \$ _____ per _____ Week _____ Month _____ Year (check one).

If you live with your spouse, his/her approximate income is \$ _____ per _____ Week _____ Month _____ Year (check one).

Do you receive money from any other source?		
Type of Income	Yes/No	If marked 'yes', list approximate amount per _____ Week _____ Month _____ Year (check one):
Allowances	<input type="checkbox"/> <input type="checkbox"/>	\$ _____
Disability	<input type="checkbox"/> <input type="checkbox"/>	\$ _____
Social Security/SSI	<input type="checkbox"/> <input type="checkbox"/>	\$ _____
Workers/Unemployment Compensation	<input type="checkbox"/> <input type="checkbox"/>	\$ _____
Trust Funds	<input type="checkbox"/> <input type="checkbox"/>	\$ _____
Alimony/Child Support	<input type="checkbox"/> <input type="checkbox"/>	\$ _____
Parents	<input type="checkbox"/> <input type="checkbox"/>	\$ _____
Other income (please describe)	<input type="checkbox"/> <input type="checkbox"/>	\$ _____

How many people are supported by this income? _____

Alternate Contact Person _____ Relationship _____
(must be able to say we are calling from Family Planning)

Address _____ Phone # _____

Insurance (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Medical Assistance/BadgerCare | <input type="checkbox"/> Co-pay/deductible insurance |
| <input type="checkbox"/> FP Waiver (PE Only or Full Coverage) | <input type="checkbox"/> Indian health services/Migrant Health |
| <input type="checkbox"/> Other Government (Medicare/Disability) | <input type="checkbox"/> No Insurance |
| <input type="checkbox"/> Full pay insurance | |

If you would like a claim submitted to your insurance company we will need to photocopy your insurance card.
 If you are submitting to insurance, you must present your card at the time of visit. If you decline to use your insurance at the time of visit, **FPHS will not submit at a later date and discounts are not available once you choose to bill Insurance.** If you have medical assistance/FP Waiver you are required to present a valid card at each visit.

I hereby certify, under penalty of perjury, that this information is accurate and complete. If my income changes, I agree to notify FPHS at my next visit.

Signature _____ Date _____

STAFF USE ONLY:

How did you hear about our services?

Income _____
 Period _____
 Family Size _____
 Income Level _____
 Check ID _____ Date _____
 Explanation of Variation:

 Staff Initials _____