FAMILY PLANNING ASSOCIATES MEDICAL GROUP, LTD

Patient Demographic and Contact Information

Please note that in the event of a missed follow up visit, abnormal lab result, medical emergency or at the request of our professional medical staff we will attempt to contact you by any means necessary.

If you receive a phone call or letter from our facility please contact us immediately to avoid additional contact attempts.

If we leave a message, would you like us to identify ourselves as your friend "Amy" instead of a doctor's office? ❒ **Yes** ❒ **No**

First Name:____ Last Name:____

Social Security Number:_________-________-__________ Date of Birth:______________________________ Age:______________

Address:____

Street Address Apartment Number City State Zip Code

Telephone Contacts: ____

Primary (Message) Phone Alternative Phone Number and/or E-mail Address

Do you live in Cook County? ❒ Yes ❒ No—If no, what county do you live in?_______________________________________

Emergency Contact:____

Full Name Relation Phone Number

How did you hear about our facility? ____

What best describes your race? ❒ American Indian or Alaska Native ❒ Black or African American ❒ White

❒ Asian Indian ❒ Chinese ❒ Filipino ❒ Japanese ❒ Korean ❒ Vietnamese ❒ Other Asian: ____________________________

❒ Native Hawaiian ❒ Guamanian or Chamorro ❒ Samoan ❒ Other Pacific Islander: __________________________________

Do you descend from Latina/Hispanic origin? ❒ No ❒ Mexican, Mexican American, Chicana ❒ Cuban

❒ Puerto Rican ❒ Other Spanish/Hispanic/Latina: ____

Are you currently a student? ❒ Yes – Full Time ❒ Yes – Part Time ❒ No

What is your highest level of education completed? ❒ 8th grade or less ❒ Some High School ❒ High school graduate

❒ Some College ❒ College Graduate ❒ Post-Graduate Degree

What best describes your marital status? ❒ Married ❒ Single ❒ Previously Married (Divorced) ❒ Living with a partner

Are you currently employed? ❒ Yes – Full Time ❒ Yes – Part Time ❒ No

What is your average monthly household income? ____

Do you have health insurance? ❒ Yes – Through my job ❒ Yes – Through my Parent/Spouse

❒ Yes – Through Medicaid / Public Aid / Pink Card ❒ No – I do not have any form of health insurance

Will you be using your health insurance for your visit today? ❒ Yes ❒ No

Please note that this information is requested for statistical purposes only. This information is required by governmental agencies and private institutions that provide financial assistance to patients. Accordingly, statistical information will be forwarded to them <u>without any unique identifiers that could allow them to discover the individual identity of any one of our patients</u>. Please be assured that your privacy is of the utmost importance to us.

Translator's Signature: ____

Revised December 2015 kp