Family Planning Client Registration: MC SEFRC SW TFRC OUTREACH

PLEASE PRINT CLEARLY

Date: _____ Client ID# _____

Legal Name: _____ Previous/maiden name: _____
Last First Middle

Birth Date: _____ Age: _____ Social Security No: _____-_____-_____

What sex were you assigned at birth, on your birth certificate? (please check one) * Female ❑ Male ❑
Preferred Name (if applicable): _____
**MCHD recognizes that there are a number of genders / sexes; many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these, please let us know.*

What is your current gender identity? Female ❑ Male ❑ Trans - Male to Female ❑ Trans - Female to Male ❑

I identify as neither exclusively Male or Female ❑ Other ❑ Pronouns: _____

Do you think of yourself as: Straight ❑ Lesbian or Gay ❑ Bisexual ❑ Other ❑

Address _____
Street Apt./Bldg. No. City State Zip Code County

Home Phone: (_____)_____ Cell Phone: (_____)_____

Email Address: _____

Emergency Contact: Name: _____Relationship: _____Phone: (_____)_____

Method of contact:
Phone: ❑Home ❑Cell OK to leave a message? ❑Yes ❑No

Mail: ❑Email ❑Mail to above address Preferred method of contact: _____

Okay to mail information or bills to your home: ❑Yes ❑No If No, where can we send mail?

_____
Street City State Zip Code

Note: We MUST have your contact information and an emergency contact person. We will make every effort to follow your preferred contact method. However, we will use all methods of contact, when a life-threatening condition is suspected or detected. If there are problems with your test results or follow-up, we will attempt to call you. If no response, we must mail information to your primary address.

Race (circle all that apply): White Black or African American Alaska Native or American Indian
Asian Hawaiian/Pacific Islander Other: (multi-racial)_____

Ethnicity (circle all that apply): Hispanic/Spanish Origin Non-Spanish Origin/Non-Hispanic
Other: _____ Primary Language: ❑English ❑Spanish ❑ Other: _____

Do you live with: Alone Boyfriend Girlfriend Parents Spouse Other:_____
(Circle all that apply)

Have you discussed your decision to seek Family Planning services with:
Your parent? Yes ❑ No ❑
Another adult? Yes ❑ No ❑

The code name **Denise** is used when a confidential message is left. If you receive a message like this, please call us. If you prefer to have the caller leave their name or MCHD in the message please indicate below:
I prefer to have caller leave their name/agency name ❑

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

Family Planning Client Insurance and Billing Information

Household Income Information (*Must be before taxes and include tips***).**

CLIENT INCOME (Circle One)

Wages	$_____	Weekly	Monthly	Annually
Unemployment	$_____	Weekly	Monthly	Annually
SSI Disability	$_____	Weekly	Monthly	Annually
Other _____	$_____	Weekly	Monthly	Annually

Staff Only:

Total Income:

_____

Circle one

Weekly Monthly Annual

Other Household Members Income (i.e.: spouse, parent, boyfriend, other)

_____ Relationship	$_____	Weekly	Monthly	Annually
_____ Relationship	$_____	Weekly	Monthly	Annually
_____ Relationship	$_____	Weekly	Monthly	Annually

Number of people this income supports _____

Private Insurance

Medical Insurance Company's Name _____

Policy or Contract Number _____ Group _____

Plan Code _____ Subscriber's Name _____

Subscriber's Relationship to Client: self ❑ spouse ❑ parent/guardian ❑ other_____

Subscriber's Address (if different from client) _____

Subscriber's Birth Date _____ Subscriber's Employer _____

Medicaid or Healthy Michigan Plan # _____

Select ONE of the following, Sign and Date:

Authorization to Bill Insurance: The information on this form is complete and accurate to the best of my knowledge. I authorize the Macomb County Health Department to release information regarding services to Third Party Payers as required for payment of benefits to Macomb County Health Department. Every attempt will be made to bill your insurance for services; however any unpaid balance will be your responsibility based on the sliding fee scale. **This authorization is for Family Planning Program services only.**

Client Signature: _____ Date: _____ ***Staff Only*:** _____
(% Sliding Fee)

Request to Restrict Insurance Information: The information on this form is complete and accurate to the best of my knowledge. I request that my information NOT be sent to private insurance Third Party Payers such as Blue Cross. I agree to pay for Family Planning Program Services based on the self-pay sliding fee scale. **This insurance information restriction is for Family Planning Program services only.**

Client Signature: _____ Date:_____ ***Staff Only*:** _____
(% Sliding Fee)

For Follow-Up Visits Only:

Date	**Check if no change in income**	**If Income *has changed*, write in the new amount**	**Client Initials**	***Staff Only:* % Sliding Fee**