Family Planning Client Registration: MC ❑ SEFRC ❑ SW ❑ TFRC ❑ OUTREACH ❑

PLEASE PRINT CLEARLY

Date: _____ Client ID# _____

Name_____
Last First Middle

Previous/maiden name _____ Social Security No _____

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

Birth Date _____ Age: _____ Sex **F** ❑ **M** ❑

Email Address _____

Phone Numbers: (include area code) ( ) _____ Do you have caller ID? **Yes** ❑ **No** ❑
Home

( ) _____ ( ) _____ ( ) _____
Work Cell/Pager Other

Can we call you at Home? Yes ❑ **No** ❑ **If not, where can we call you?** ( )_____

Mail information or bills to your home? Yes ❑ **No** ❑

If not, where can we send mail? _____
(Required) Street City State Zip Code

Emergency phone: ( ) _____ Name: _____

Relationship: _____

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_____

Marital Status: Never Married Married Divorced Widowed Separated

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 message is left. If you receive a message like this, please call us.

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

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

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

Total Income $_____	**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