FAMILY PLANNING ASSOCIATES MEDICAL GROUP, LTD

Patient Demographic and Contact Information

First Name _____ Last Name _____

Last 4 digits of your Social Security Number _____ Date of Birth _____

Address _____
Street Address Apartment Number City State Zip

What COUNTY do you live in? _____ Email _____

Phone Number(s) _____
Primary (Message) Phone Alternative Phone Number

What best describes your race/ethnicity?	**What kind of health insurance do you have?**
❒ Black, Non-Hispanic	**(Check all that apply)**
❒ Hispanic	❒ Illinois Medicaid
❒ White, Non-Hispanic	❒ Medicaid from my home state listed above
❒ Native American or Alaska Native, Non-Hispanic	❒ Private Insurance—PPO or HMO (through my job/parent/spouse/purchased independently)
❒ Asian or Pacific Islander, Non-Hispanic	❒ None
	Are you using your insurance today? ❒ YES ❒ NO

Please note that if you do not provide payment for the services you receive, we reserve the right to bill your insurance. ***If you do not want your insurance billed it is your responsibility to make sure that payment for services rendered is made before you leave our office.***

EMERGENCY CONTACT(S)

_____

Full Name **Relation to you** **Phone Number**

_____

Full Name **Relation to you** **Phone Number**

Do your Emergency Contacts know that you are at FPA today? ❒ **Yes** ❒ **No**

PRIVACY PREFERENCES

Is it OK for us to leave a detailed message on your Primary Phone? ❒ **Yes** ❒ **No**

Do you have any special privacy concerns? ❒ **Yes** ❒ **No**

If 'YES' what can we do to help? _____

_____

Please note that in the event of a critical missed follow up visit, abnormal lab result, medical emergency or at the request of our medical staff we will attempt to contact you by any means necessary. If you receive a phone call or letter from FPA please contact us immediately to avoid additional contact attempts.