

WOMANKIND CLIENT REGISTRATION

Last name _____ First _____ M.I. _____

Address _____

City _____ State _____ Zip Code _____

Social Security Number _____ Date of Birth _____

Nickname _____ Age _____

Primary language spoken _____

OK to receive post mail from us? _____

NOTE: Please understand that if we need to get in touch with you about abnormal test results and we are unable to reach you by phone and you do not return our phone calls, we are required to send letters to your mailing address. Your signature here indicates your understanding: _____.

Email Address _____

Home phone _____ OK to call? _____

Cell phone _____ OK to call? _____

Work phone _____ OK to call? _____

Race _____ Ethnicity _____

If teen, what school do you go to? _____

Circle one: Single, Married, Domestic Partnership, Separated, Divorced, Widowed

Client employed by _____ Full time ___ Part time ___ Occupation _____

Business Address _____ Supervisor _____

Spouse/responsible party _____ Relationship _____

Spouse employed by _____ Occupation _____

Do you have medical insurance? _____ Name of Insurance _____

In case of emergency, who should be notified? _____

Relationship _____ Phone (H) _____

(W) _____ (C) _____

How did you hear about WomanKind? _____

Consent to Treatment

I hereby consent to medical treatment by the signing of this document. I understand that all fees are due at the time of service, and are not contingent on any judgment settlement or insurance payment by which I may recover said fees. I understand that services are provided on a voluntary basis, and that I do not have to accept any method of family planning. I hereby authorize WomanKind, inc. to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claims.

Client Signature _____ Date _____

Health Information Privacy Policy Acknowledgement

I, the undersigned acknowledge that I received a copy of WomanKind's Notice of Privacy Practices which outlines policies, practices and procedures employed by WomanKind to assure confidentiality of my medical records.

Client signature _____ Date _____