STAFFORD COUNTY HEALTH DEPARTMENT
FAMILY PLANNING PROGRAM CLIENT REGISTRATION FORM

Last Name:____________________________ First Name:____________________________ M.I.________

Maiden Name:_________________________ Marital Status: __ Single __ Married __ Divorced __ Widowed

Birth Date:________________ SS#:_____________ Sex: __ Female __ Male

Address:_________________________ City:_________________________ State:_______ Zip:___________

Home Phone:____-____-______ Cell Phone:____-____-______

Email:____
May we contact you at the above address? Yes No
May we contact you at the above phone number(s)/email address? Yes No
If NO, how may we contact you?____

RACE: (mark all that apply)
__White __Black or African American __American Indian/Alaskan Native __Asian __Native Hawaiian/Pacific Islander
__Unknown/Not Reported

Hispanic/Latino Origin: Yes No

Primary Type of Health Coverage:
__Medicaid __Other Public Insurance __Private Insurance __No Coverage
__Unknown

Guarantor: (if different from above)
Last Name:____________________________ First Name:___________________________ Relationship:_________

Address:_________________________ City:__________________________ State:_______ Zip:___________

Home Phone:____-____-______ Cell Phone:____-____-______

INCOME
(Proof of income must be provided at the time of your annual exam. Please bring a paystub with you to your appointment or you will not be able to participate in the sliding fee discount.)
Total Income: $ _________ per (circle one): Year Month Week Hour
Number of persons supported by this income: _______

I certify that all the above information is correct to the best of my knowledge.

___________________________________ ____________
(Signature of Client) **(Date)**

FOR STAFF USE ONLY: Annual Income Assessment: ______________ Level of Discount: ____________
English as Primary Language? □ Yes (Speaks/Understands English)
□ No (Bilingual Staff/Interpreter Services Used)

(Signature of Staff) (Date) Client ID