pregnancy care center

REQUEST FOR SERVICES

Date_____

Name: _____ DOB: _____ Gender: (M) / (F) Age: _____

Mailing Address: _____City_____State____Zip_____

Cell Phone: _____ Home Phone: _____

Email: _____

Please note that we will be contacting you for follow up services.

May we leave a message at the phone number(s) listed above? ◯Yes ◯No

May we send mail to the address listed above? ◯Yes ◯No

REASON FOR YOUR VISIT: ☐Pregnancy Test ☐Ultrasound ☐Nurse Consultation

# of tW2N Pregnancies: _____ Outcome of Pregnancies: # ___ Births #___Miscarriages #___ Abortions

CWăű day of your fl-ăű period _____

How did you hear about us?

	PLACE	AROUND TOWN
☐ Returning Patient	☐ Women's Health Center	☐ Billboard
☐ Friend/Relative	☐ Rogue Birth Center	☐ Sign on 7th St.
Do you know how they heard about us?_____	☐ Church: _____	☐ Bus Ad
	☐ School: _____	☐ Poster/Banner:_____
INTERNET	PRINT	MUSIC
☐ Search Engine: _____	☐ Rogue Valley Messenger	☐ Spotify
☐ Social Media Platform:_____	☐ Sneak Preview	☐ KLDR Radio

OTHER (please specify):_____

What is your living situation?

☐ Boyfriend	☐ Spouse	☐ Alone	☐ Shelter
☐ Girlfriend	☐ Friend/Roommate	☐ Foster Parents	☐ Homeless
☐ Fiancée	☐ Parents	☐ Grandparents	☐ Other:_____

Relationship Status:

☐ Divorced	☐ Engaged	☐ Living Together
☐ Married	☐ Separated	☐ Single

Insurance Coverage:

☐ OHP ☐ None

☐ Private Insurance _____

Religious Beliefs:

☐ Atheist	☐ Catholic	☐ Hindu	☐ Jewish	☐ Muslim/Islam
☐ Buddhist	☐ Christian (protestant)	☐ Jehovah's Witness	☐ Mormon	☐ Other: _____

How are you financially supported?

☐ Boyfriend	☐ Child Support	☐ Friends	☐ Parents	☐ Unemployment
☐ Girlfriend	☐ Employed	☐ SSI Disability	☐ WIC	☐ TANF
☐ Fiancée	☐ Food Stamps(SNAP)	☐ Spouse	☐ Other:_____	

OFFICE USE ONLY ☐ **Note in eFile**

File # _____ eFile # _____

☐ Photo ID

☐ Photo

Reviewed by: _____

☐ **RETURN - Last RSF Date: _____**

After reading the statements below, please put your initials on each line.

_____ ***The PCC Medical Program*** offers early pregnancy health services at no cost and serves as a gateway to ongoing obstetrical care. Our medical services are provided under the direction and supervision of a licensed Physician and implemented by licensed Medical Providers.

_____ PCC is a place where you can feel safe and be treated with respect at all times. All of our services are free of charge. **All information is confidential unless mandatory reporting laws apply or if we suspect you are in danger, or are in danger of hurting yourself or others.**

_____ PCC's services are not a substitute for professional counseling or follow-up medical services with a Physician.

_____ PCC's goal is to equip you by giving you facts, information, and through the use of a decision guide, help you make an informed decision. All of our staff is fully trained.

_____ We sometimes provide informal referrals for medical care, professional counseling, and other community services, we assume no legal responsibility for services provided by other agencies or individuals; nor are the views of these organizations/individuals necessarily the views of PCC.

_____ PCC is not an adoption agency nor are we affiliated with any adoption agency.

_____ **PCC does not perform nor directly refer for abortions**, nor do we dispense birth control.

_____ Our Pathways program offers individual support and group classes for expecting parents.

Following your appointment, a PCC representative will be contacting you with additional information and support. By signing this form you give permission for a PCC Representative to contact you. **If you fail to respond to our calls or texts we may be required to send you a certified letter to your preferred mailing address.**

No recordings are permitted. Confidentiality applies for all appointments. PCC and its representatives (paid and volunteer) do NOT consent to having any conversations recorded.

I have read and understood the above and hereby authorize the staff of PCC to render whatever services are necessary for my care.

_____ _____

Signature Date

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