

Patient Demographic Form

Please complete this form in order to ensure proper billing of your services.

Patient Information

Last Name: _____ First Name: _____ Today's Date: _____
Other Name: _____ Date of Birth: _____ Soc. Sec. No: _____
Address (street): _____ City, State, Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
PCP: _____ Ref. Physician (if different): _____
Address (street): _____ Address (street): _____
City, State, Zip: _____ City, State, Zip: _____
Telephone #: _____ Telephone #: _____
Sex: Male Female Marital Status: Single Married Widowed Separated Divorced Partner

Employment Information

Employer: _____
Employer Address (street): _____ City, State, Zip: _____
Emp. Status: Full Time Part Time Not Employed Self-Employed Active Military
Student Status: Full Time Student Part Time Student

Insurance Information

PRIMARY CARRIER NAME: _____ Telephone #: _____
Address: _____ City, State, Zip: _____
ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____
SECONDARY CARRIER NAME: _____ Telephone #: _____
Address: _____ City, State, Zip: _____
ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____

Parent / Guardian Information

Contact: _____ Relationship to You _____
Home Phone: _____ Alt. Phone: _____
Contact: _____ Relationship to You _____
Home Phone: _____ Alt. Phone: _____

Electronic Communications

Portal: We offer secure electronic communications between you and our office via our Patient Portal. Secure messages and information can only be read by someone who knows the right password to log in to the Portal site. The communications are automatically encrypted and for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information.

- Yes, I want to participate, please use the email provided on my HIPAA form.
 No, I do not wish to participate.

SIGNATURE OF PATIENT OR REPRESENTATIVE

DATE

Automated Calls: As an added convenience, we offer automated appointment reminders via a text message or an automated call for those who want to participate. The reminders are sent from a computer and cannot be used as a way for you to communicate back to us. If you should need to reach us, please call our main number. If at any time you should change your mind, please let us know what other method you would prefer for appointment reminders.

I understand under the telephone consumer protection act, that in order for you to contact me by automated means for services relating to my medical care, including appointment reminders, monies I may owe, etc., I agree that Axia Women's Health and/or your agents may contact me by my cell phone, which may result in charges to me. You may also contact me by text messages, or emails providing that I have consented above. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automated dialing device, as applicable.

Yes, I agree to participate in automated dialing, my cell number is provided below.

Cell Phone Number: _____

No, I do not wish to participate.

SIGNATURE OF PATIENT OR REPRESENTATIVE

DATE

Additional Information

Race: Which category best describes your racial background?

- | | |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Unreported/Refused to Report |

Ethnicity: How would you describe you ethnicity, such as your family background or ancestry?

- Hispanic or Latino Not Hispanic or Latino Unreported/Refused to Report

Preferred Language: What language do you usually speak at home?

- English Spanish Other _____

How did you hear about our practice?

- Health Plan Internet Our Web Site ER/Hospital
 Newspaper/Magazine Patient _____ Other _____

Pharmacy Information

Pharmacy Name: _____ Local Mail away

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

Pharmacy Name: _____ Local Mail away

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

SIGNATURE OF PATIENT OR REPRESENTATIVE

DATE