

## 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?

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Unreported/Refused to Report |
|---|---|---|

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

- |                                  |                                  |                                      |
|----------------------------------|----------------------------------|--------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> Other _____ |
|----------------------------------|----------------------------------|--------------------------------------|

How did you hear about our practice?

- |   |  |                                       |                                      |
|---|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Health Plan        | <input type="checkbox"/> Internet      | <input type="checkbox"/> Our Web Site | <input type="checkbox"/> ER/Hospital |
| <input type="checkbox"/> Newspaper/Magazine | <input type="checkbox"/> Patient _____ | <input type="checkbox"/> 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