Axia Women's Health

Patient Demographic Form

Patient Information

Last Name: ______________________ First Name: ____________________ Today's Date: ________

Other Name: ______________________ Date of Birth: ____________ Soc. Sec. No: ______________

Address (street): ______________________________ City, State, Zip: __________

Email Address: ______________________________Home Phone:______________________________

Cell Phone:______________________Work Phone:____________________________Ext__________

PCP: ____________________________ Address (street):________________________________

City, State, Zip: ___________________________ Telephone #: ___________________________

Sex: ☐ Male ☐ Female **Marital Status**: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partner

Preferred Language: ☐ English ☐ Spanish ☐ Other ________________

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Black or African American ☐ White ☐ Refused to Report **Ethnicity**:☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused to Report

Emergency Contact

Name:____________________________Relationship: __________________Phone:__________________

Electronic Communications

Email: I understand Axia will **not** share my email address with any third parties. My address will be used to communicate important announcements about my care center or provider, such as office closings, changes in services, and other non-clinical announcements pertaining to Axia or my care center. Axia offers secure electronic communications between patients and their office via the Patient Portal.

☐ Yes, I want to participate. Please use the email address above. ☐ No, I do not wish to participate.

Automated Reminders: Axia Women's Health offers automated reminders via text messages or automated calls. If I choose to participate, I understand my cell phone listed above will be used.

☐Yes, I agree to participate. (Please choose one method) ☐ Text messages ☐ Voice calls

☐No, I **do not** wish to participate.

I agree that Axia Women's Health and/or it's agents may contact me by cell phone, including via text messages or automated calls, which may result in charges to me.

e-Prescription Consent for Medication History

With my consent, Axia may request and use my prescription medication history information using their e-prescription feature. This is for only informational purposes, so an up-to-date record of my medication is available for my treatment and safety.

☐ Yes, I give consent to obtain my medication history using the e-Prescribing feature.

☐ No, I do not give consent to obtain my medication history using the e-Prescribing feature. I understand that my medication information may not be complete when making treatment decisions.

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: __________

Pharmacy Information

Pharmacy Name: ______________________________ ☐ Local ☐ Mail away

Address: ______________________________ City, State, Zip: ______________

Phone: ______________________________ Fax: ______________

Pharmacy Name: ______________________________ ☐ Local ☐ Mail away

Address: ______________________________ City, State, Zip: ______________

Phone: ______________________________ Fax:

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

Additional Information

How did you hear about our practice? Please check all that apply:

☐ Advertisement- Print or Magazine ☐Community Event/Presentation ☐ Google or another Search Engine

☐ Advertisement- Billboard ☐ Insurance Directory ☐ Social Media ☐ Signage/Drive-by ☐ Website

☐ Advertisement- Online ☐ Referral from friend or relative ☐Referral from a provider. Who: ______________

____ ______________

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE