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: _________________________________ PCP Tele #: _________________________________

Birth Sex: ☐ Male ☐ Female **Gender Identity:** ☐ Male ☐ Female ☐ Genderqueer, neither exclusively male nor 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 ☐ Refuse to Report **Ethnicity**: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refuse to Report

Emergency Contact

Name: ________________________________ Relationship: ____________________ Phone: __________________

Electronic Communications

Email: I understand Axia Women's Health 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 its 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