



REGISTRATION UPDATE FORM

Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_
Other Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
Address (street): \_\_\_\_\_ City, State, Zip: \_\_\_\_\_
Email Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_
Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext \_\_\_\_\_
PCP: \_\_\_\_\_ PCP Telephone # \_\_\_\_\_
Sex: [ ] Male [ ] Female Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced [ ] Partner

Pharmacy Update Information

Pharmacy Name: \_\_\_\_\_ [ ] Local [ ] Mail away
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_
Pharmacy Name: \_\_\_\_\_ [ ] Local [ ] Mail away
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Insurance Information

PRIMARY CARRIER NAME: \_\_\_\_\_
ID/Cert #: \_\_\_\_\_ Group/Plan #: \_\_\_\_\_ Effective Date: \_\_\_\_\_
SECONDARY CARRIER NAME: \_\_\_\_\_
ID/Cert #: \_\_\_\_\_ Group/Plan #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

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.

Medical Chaperone

I request a female chaperone to be present during my examination? [ ] Yes [ ] No [ ] Other (family member, partner, etc. will be present)

Patient Signature

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my provider or insurance company to release any information required to process my claims.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_