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 # _____

Birth Sex: ☐ Male ☐ Female **Gender Identity:** ☐ Male ☐ Female ☐ Genderqueer, neither exclusively male nor 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: _____