Women's Physicians & Surgeons
an Axia Women's Health Care Center

# 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:___________________________ Social Security # ________________

Address (Street): _____________________________________________City, State, Zip: ____________________________________

Home Phone #: ___________________________ Cell Phone # ___________________________ Work # ________________________

PCP (Primary Care Physician): ___________________________ Referring 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 ______________________________

Employment Status: □ Full Time □ Part Time □ Not Employed □ Self-Employed □ Active Military

Student Status: □ Full Time Student □ Part Time Student

## ***Parent / Guardian Information***

Contact:_____________________________________________ Relationship to You: _________________________________

Home Phone #: _____________________________________ Alternate Phone #: __________________________________

Contact:_____________________________________________ Relationship to You: _________________________________

Home Phone #: _____________________________________ Alternate 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 into 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 HIPPA form.

□ No, I do not wish to participate.

_________________________________________________________________ __________________________________________

Signature of Parent 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 Regional Women's health Group, LLC 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 phone number is provided below.

Cell Phone Number: ___________________________

□ No, I do not wish to participate.

_________________________________________________________________ __________________________________________

Signature of Parent or Representative Date

***Additional Information***

Race: Which category best describes your racial background?

- ◻ American Indian or Alaska Native
- ◻ Native Hawaiian or Other Pacific Islander
- ◻ Asian
- ◻ White
- ◻ Black or African American
- ◻ Unreported/Refused to Report

Ethnicity: How would describe your Ethnicity, such as your family background or ancestry?

◻ Hispanic or Latino ◻ Spanish ◻ Other ____________________

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

◻ English ◻ Spanish ◻ Other ____________________

How did you hear about our practice? ◻ Health Plan ◻ Internet ◻ Our Web Site ◻ ER/Hospital

◻ Newspaper/Magazine ◻ Patient___________________________ ◻ 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 Parent or Representative Date