

# 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: \_\_\_\_\_  
Address (street): \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
PCP: \_\_\_\_\_ Ref. 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: \_\_\_\_\_  
Emp. Status:  Full Time  Part Time  Not Employed  Self-Employed  Active Military  
Student Status:  Full Time Student  Part Time Student

## Emergency Contact Information

Emergency Contact: \_\_\_\_\_ Relationship to You \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_

## Insurance Information

PRIMARY CARRIER: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
ID/Cert #: \_\_\_\_\_ Group/Plan #: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
SECONDARY CARRIER: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
ID/Cert #: \_\_\_\_\_ Group/Plan #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

## Parent/Guardian Information

Contact: \_\_\_\_\_ Relationship to You \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_  
Contact: \_\_\_\_\_ Relationship to You \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Alt. 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 in to 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, my email is provided below.

Home Email: \_\_\_\_\_

No, I do not wish to participate at this time.

\_\_\_\_\_  
SIGNATURE OF PATIENT 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 for services relating to my medical care, including monies I may owe, I agree that Regional Women's Health Group, LLC and/or your agents may contact me by telephone, including 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 want to participate, my cell number is provided below.

Cell Phone Number: \_\_\_\_\_

No, I do not wish to participate at this time. I would prefer to be notified by:

- Mail       Telephone       e-mail (via the Portal – you will need to participate, see above.)

\_\_\_\_\_  
SIGNATURE OF PATIENT 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 you describe you ethnicity, such as your family background or ancestry?

- Hispanic or Latino       Not Hispanic or Latino       Unreported/Refused to Report

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 PATIENT OR REPRESENTATIVE

\_\_\_\_\_  
DATE