Main Line OB GYN
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: _____ Soc. Sec. No: _____

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

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: _____

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, please use the email provided on my HIPAA form.

☐ No, I do not wish to participate.

_____ _____

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 by automated means for services relating to my medical care, including appointment reminders, monies I may owe, etc., I agree that Axia Women's Health 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 number is provided below.

Cell Phone Number: _____

☐ No, I do not wish to participate.

_____ _____

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