Axia WOMEN'S HEALTH

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Established Patient Update Form

Patient Information:

Last Name: _____ **First Name**: _____ **Today's Date**: _____

Other/Maiden Name: _____ **Date of Birth:** _____

Address: _____ **City, State, Zip**: _____

Cell Phone: _____ **Other Phone:** _____

Email: _____
(By providing your email, you will be receiving communications regarding our patient portal and care center services)

What is your preferred method of communication (Mark all that apply):
☐ Cell Phone – Text ☐ Cell Phone – Voice ☐ Other Phone ☐ Email

Is it okay to leave a brief message with medical information and/or appointment reminders to your preferred method of communication? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Domestic Partner

Spouse/Domestic Partner Name: _____

Employment Information

Employment/Student Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Self-Employed ☐ Active Military

☐ Retired ☐ Full-Time Student ☐ Part-Time Student

Employer: _____

Occupation: _____ **Phone:** _____

Minor Information (under 18 and not emancipated)

Parent/Legal Guardian Name: _____ **Phone:** _____

Relationship: ☐ Parent ☐ Grandparent ☐ Other Relative ☐ Other _____

Emergency Contact

Name: _____ **Phone:** _____

Relationship: ☐ Spouse/Partner ☐ Parent ☐ Child ☐ Other Relative ☐ Friend ☐ Other

Primary Care Provider/Referring Provider

Primary Care Physician: _____ **Phone:** _____

Address: _____

Referring Physician (if different): _____ **Phone:** _____

Address: _____

Pharmacy Information

Local Pharmacy Name: _____ **Phone**: _____

Address: _____ **City, State, Zip**: _____

Mail In Pharmacy Name: _____

Insurance Information

Primary Insurance Provider: _____

Policy Holder Name: _____ **Policy Holder DOB:** _____

Policy Holder Employer: _____

Secondary Insurance Provider: _____

Policy Holder Name: _____ **Policy Holder DOB:** _____

Policy Holder Employer: _____

Friends and Family involved in care (Optional)

I give permission for the following individuals to receive information about my treatment and payment to assist in my healthcare. I understand this permission is valid until revoked.

Name: _____ **Phone:** _____

Relationship: ☐ Spouse/Partner ☐ Parent ☐ Child ☐ Other Relative ☐ Friend ☐ Other

Name: _____ **Phone:** _____

Relationship: ☐ Spouse/Partner ☐ Parent ☐ Child ☐ Other Relative ☐ Friend ☐ Other

By signing below, I acknowledge I have read, understand, and agree to the above regarding Authorization for Treatment, Payment and Healthcare operations.

_____

Patient/Authorized Signature **Date**