

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?

- | | |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Unreported/Refused to Report |

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Unreported/Refused to Report |
|---|---|---|

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

- | | | |
|----------------------------------|----------------------------------|--------------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> Other _____ |
|----------------------------------|----------------------------------|--------------------------------------|

How did you hear about our practice?

- | | | | |
|---|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Health Plan | <input type="checkbox"/> Internet | <input type="checkbox"/> Our Web Site | <input type="checkbox"/> ER/Hospital |
| <input type="checkbox"/> Newspaper/Magazine | <input type="checkbox"/> Patient _____ | <input type="checkbox"/> 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

Patient's Name: _____

DOB: _____

Authorization for Treatment & Payment of Medical Benefits Patient Financial Responsibility Form

Thank you for choosing our practice, an Axia Women's Health Care Center, as your healthcare provider. We appreciate the confidence you have shown by your choice and are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies. If you would like to receive a more detailed explanation of our financial policies, please request a copy.

Authorization for Treatment & Payment of Medical Benefits

I give permission to the practice, an Axia Women's Health Care Center, to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice, an Axia Women's Health Care Center.

Use of Photography

I agree that any photo identification taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of identification.

e-Prescription Consent for Medication History

With your consent, we may request and use your prescription medication history information using our e-prescription feature. This is for only informational purposes so that an up-to-date record of your medication is available for your treatment and safety.

- Yes, I give consent to obtain my medication history using the e-Prescribing feature.
- No, I do not give consent to obtain my medication history using the e-Prescribing feature. I understand that my medication information may not be complete when making treatment decisions.

Patient Financial Responsibilities

- I (or patient's guardian, if a minor) understand that I am ultimately responsible for the payment of my treatment and care.
- You will assist me by billing your contracted insurers. However, I understand that I am required to provide you with the most correct and updated information about my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand that payment is due at the time of service, payable by cash, check, and most major credit cards.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include (but are not limited to):
 - Charge for returned checks.
 - Charge for the copying and distribution of patient medical records.
 - Charge for forms completion.
 - Charge for missed appointments.

Patient Authorizations

- By my signature below, I hereby authorize the practice, an Axia Women's Health Care Center, to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services.
- By my signature below, I hereby authorize assignment of financial benefits directly to the practice, an Axia Women's Health Care Center. I understand that I am financially responsible for charges not covered or denied in full or in part by my insurance plan(s).

I have read, understand, and agree to the provisions of this Authorization for Treatment & Payment of Medical Benefits and Patient Financial Responsibility Form:

Signature of Patient or Guardian _____

Date _____

HIPAA Acknowledgements and Authorizations

I. HIPAA Notice of Privacy Practices

Patient Acknowledgement

We are required by law to maintain the privacy of protected health information, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review our Notice of our Privacy Practices:

Print Name: _____ Date of Birth: _____

Signature: _____ Date: _____

II. Authorization for use or Disclosure of Health Information

Patient Contact Information

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

I authorize Brief messages with medical information to be left on voicemail at (check all that apply): Home Cell Work

I authorize Extended messages with medical information to be left on voicemail at (check all that apply): Home Cell Work

I authorize secure electronic communications be sent to my email address at: _____

Restrictions/Instructions: _____

Release of Medical History and Treatment Information

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

Name: _____ Relationship: _____ DOB: _____ Ph #: _____

Name: _____ Relationship: _____ DOB: _____ Ph #: _____

Restrictions: _____

Release of Billing Information

I authorize the following individual(s) to receive information pertaining to any billing issue and to act on my behalf:

Name: _____ Relationship: _____ DOB: _____ Ph #: _____

Name: _____ Relationship: _____ DOB: _____ Ph #: _____

Restrictions: _____

Patient Acknowledgement

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office address. My revocation will be effective once received by the practice, an Axia Women's Health Care Center.
2. A copy of this authorization may be used with the same effectiveness as the original.

This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Print Name: _____ Date: _____

Signature: _____ Relationship: _____

Additional Authorizations

Emergency Contact: _____ Relationship: _____ Phone: _____

I request a female chaperone to be present during my examination? Yes No Other _____

Duration: How long does your period last? < 7 days 2 - 7 days 3 days

Pad / Tampon Use Per Day: 1-3 4-6 7+

Associated Signs/ Symptoms: How would you describe your period:

- | | |
|---|---|
| <input type="checkbox"/> with severe pain | <input type="checkbox"/> with moderate pain |
| <input type="checkbox"/> with mild discomfort | <input type="checkbox"/> without discomfort/ pain |
| <input type="checkbox"/> heavy | <input type="checkbox"/> light |

Menstruation Symptoms:

Premenstrual Syndrome: Yes No

If yes, please mark any symptoms you are experiencing:

- | | | | |
|---|--------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Tension | <input type="checkbox"/> Pelvic pain |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Tiredness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Bowel changes | <input type="checkbox"/> Bloating | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Changes in desire |
| <input type="checkbox"/> Breast swelling/discomfort | | | |

Menopause: Yes No

If yes, began at age: _____

Current menopausal symptoms:

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Loss of Sexual Desire |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Vaginal dryness |

Self Breast Exam: Monthly Do not perform Sometimes

Birth Control:

- | | |
|---|---|
| <input type="checkbox"/> Condoms | |
| <input type="checkbox"/> Oral contraceptive pills | Indicate which pill: _____ |
| <input type="checkbox"/> Mirena IUD | <input type="checkbox"/> Paraguard IUD |
| <input type="checkbox"/> Skyla IUD | <input type="checkbox"/> Diaphragm |
| <input type="checkbox"/> Nuvaring | <input type="checkbox"/> Bilateral Tubal Ligation |
| <input type="checkbox"/> Vasectomy | <input type="checkbox"/> None |
| <input type="checkbox"/> Depo-Provera | <input type="checkbox"/> Ortho Evra Patch |
| <input type="checkbox"/> Spermicide | <input type="checkbox"/> Nexplanon |

If using an IUD or Nexplanon, please list the date of insertion (mm/yy): _____

Sexual activity:

Currently sexually active Not currently sexually active

Total Number of Sex Partners: _____

Past history of sexual abuse: _____

Currently or in the past, I have had sex:

With men With women With both men and women

Sexually Transmitted Infections (STI's)?

- | | |
|---|---|
| <input type="checkbox"/> None | |
| <input type="checkbox"/> Human Papilloma Virus (HPV) | <input type="checkbox"/> Herpes Simplex Virus (HSV) |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Human Immunodeficiency Virus (HIV) | <input type="checkbox"/> Trichomoniasis (Trich) |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Syphilis | |

Have you had a Gardasil HPV Vaccine: Yes No

OB History

Total pregnancies: _____ Total living children: _____

Total full term pregnancies: _____ Total pre term pregnancies: _____

Total miscarriages/abortions: _____

Total Ectopic Pregnancies: _____

Please fill out the following to the best of your recollection regarding prior pregnancies:

Birth Date	# Weeks Pregnant at Birth	Hours in Labor	Birth Weight	Anesthesia	Deliver Method	Delivery Location & Provider
					<input type="checkbox"/> vaginal <input type="checkbox"/> c-section	
Comments or Complications (i.e. diabetes, blood pressure, etc.)						
					<input type="checkbox"/> vaginal <input type="checkbox"/> c-section	
Comments or Complications (i.e. diabetes, blood pressure, etc.)						
					<input type="checkbox"/> vaginal <input type="checkbox"/> c-section	
Comments or Complications (i.e. diabetes, blood pressure, etc.)						

Surgical History

Please list any previous surgeries and c-sections (include minor surgeries like wisdom teeth, appendix, etc.). Please indicate approximate date:

Have you ever had a blood transfusion? Yes No

Hospitalizations:

Please list any hospitalizations:

Current status unknown Nonsmoker Unknown if ever smoked

How many cigarettes a day do you smoke?

5 or less 6-10 11-20 21-30 31 or more

Are you interested in quitting?

Ready to quit Thinking about quitting Not ready to quit

Alcohol:

Did you have a drink containing alcohol in the past year?: Yes No

How often did you have a drink containing alcohol in the past year?

Never Monthly or less 2-4 times a month 2-3 times a week
 4 or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

1-2 drinks 3-4 drinks 5-6 drinks 7-9 drinks 10 or more drinks

How often did you have 6 or more drinks on one occasion in the past year?

Never Less than monthly Monthly Weekly Daily or almost daily

Drugs:

Have you used drugs other than those for medical reasons in the past year? Y N

Caffeine Intake: None 1-2 cups per day 2-3 cups per day

3-4 cups per day More than 4 cups per day

Exercise Frequency: Never Occasionally 1-2 times per week

2-3 times per week 3-4 times per week 4-7 times per week

Any history of domestic violence?

None History in the past Has restraining order

Feel unsafe at home Have a safety plan

Any history of verbal abuse?

None Occasional Frequent

Seeking counseling Has safety plan

Has your current partner ever threatened you or made you feel afraid?

Yes No

Does your current partner or someone important to you hurt you physically or emotionally? Yes No

CANCER HISTORY FORM

Name: _____

Date: _____

Date of Birth: _____

I HAVE HAD CANCER GENETIC TESTING:

YES WHEN? _____ RESULTS: Negative Positive, Gene: _____

NO → **PLEASE COMPLETE FORM BELOW**

If you have either of the following insurances, please indicate by checking the corresponding box:

Amerigroup (Medicaid)

Medicare (Do you have a secondary insurance? Y/N)

Please provide information about the cancer in yourself and/or family in the table below. Specify who had what kind of cancer, and estimate the age of diagnosis. Include information on yourself and the following relatives on both sides of your family:

Parents, Siblings, Children, Grandparents, Aunts, Uncles, Nieces, Nephews, Cousins

CANCER HISTORY		You	Siblings/ Children	Mother's Side	Father's Side	Age of Diagnosis
No	Yes	Breast Cancer UNDER AGE 50				
No	Yes	Ovarian Cancer at ANY age				
No	Yes	Ashkenazi Jewish with one Breast, Ovarian, or Pancreatic Cancer at ANY age				
No	Yes	3 OR MORE Breast, Prostate, or Pancreatic Cancers (same family side at ANY age)				
No	Yes	Male Breast Cancer at ANY age				
No	Yes	Colon or Endometrial/Uterine Cancer diagnosed under age 50				
No	Yes	3 OR MORE Colon, Endometrial/Uterine, Gastric, Pancreatic Cancers (same family side at ANY age)				
No	Yes	Have YOU been diagnosed with endometrial/uterine cancer?				

Have any of your family members had genetic testing? _____

Patient Signature _____

OFFICE USE ONLY

Patient offered genetic testing: Yes / No Accepted / Declined / Informed

Provider Initials: _____

*As we comply with
government requirements
in an effort to protect your
identity, you will be
required to show your
picture id and insurance
card at each visit.*

*Thank you for your
cooperation.*