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DEMOGRAPHIC FORM

Advanced Women's Health OB/GYN

PATIENT INFORMATION

Last Name	First Name	Middle Initial:	Nickname

Social Security Number	Date of Birth	Sex ☐ M ☐ F	Marital Status: ☐ Divorced ☐ Single ☐ Married ☐ Widowed ☐ Separated

Primary Care Physician	Home Phone Number

Patient Street Address *(Required)*	Cell Phone Number

City	State	Zip Code	E-Mail Address

P.O. Box	P.O. Box Zip Code	Race:	Language:	Ethnicity:

Employer Name	Employer Phone Number

Employer Address *(Street, P.O. Box)*	City	State	Zip Code

Reason for Visit	How did you hear about us?

RESPONSIBLE PARTY

Last Name	First Name	Middle Initial	Phone Number

PHARMACY INFORMATION

What Pharmacy Do You Use?

City	State	Zip Code	

How are you paying today? ☐ Insurance ☐ Self-Pay ☐ Credit Card ☐ Check ☐ Cash

EMERGENCY CONTACT

Last Name	First Name	Middle Initial	Phone Number

Street Address *(Required)*	P.O. Box *(if applicable)*

City	State	Zip Code	*Okay to discuss details of care?* ☐ Yes ☐ No

Relationship to Patient: ☐ Child ☐ Spouse ☐ Mother ☐ Father ☐ Boyfriend ☐ Other:

Same address as patient? ☐ Yes ☐ No

PRIMARY INSURANCE

Name of Insurance:

Subscriber's Name (if different from patient): *(Last, First, MI)*

Member ID # *or* Policy #:	Group #:

Medicaid *or* Medicare ID #:	Subscriber's Date of Birth:

Relationship to Patient:
☐ Child ☐ Step Child ☐ Spouse ☐ Self – Patient is the policyholder

Patient is Self-Pay? ☐ Yes ☐ No	Copay: $

SECONDARY INSURANCE

Name of Insurance:

Subscriber's Name (if different from patient): *(Last, First, MI)*

Member ID # *or* Policy #:	Group #:

Medicaid *or* Medicare ID #:	Subscriber's Date of Birth:

Relationship to Patient:
☐ Child ☐ Step Child ☐ Spouse ☐ Self – Patient is the policyholder

Patient is Self-Pay? ☐ Yes ☐ No	Copay:	$