Patient Demographic Form

Patient Information

Last Name: ___________________________ First Name: ___________________________ Middle Name: ___________________________

Preferred Name: __________________________ Maiden Name: _______________________ Pronouns: ____________________________

Date of Birth: ______ /_____ /_____ Social Security Number: __________________ Email Address: ______________________________

Address: ____ City: _______________________ State: ____________ Zip: ________________

Home Phone #: (___)___________________ Cell Phone #: (____)_______________ Work Phone #: (___)_________________________

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Other Circumstance: _______________________

Employer Name: ___________________________________ Occupation: ____

Marital Status: ☐ Single ☐ Married ☐ Other Circumstance: ____

Race: ____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Are you adopted? ☐ Yes ☐ No Please provide more information if needed: ____

Preferred Language: ____

Preferred Pharmacy: ____ Phone #: _____________________________________

Emergency Contact: ______________________________ Relationship: ________________ Phone #: ______________________________

How did you hear about Avina? ☐ Google (search engine) ☐ Social Media ☐ TV ☐ Other ______________________________

Primary Insurance Information

Name of Insurance: ____ Effective Date: ____ /____ /___________

Policy Holder's Name: ___________________ Relation to Patient: ________________ Policy Holder's D.O.B.: ____ /____ /___________

Policy Holder's S.S. #: ____________________________ Policy #: _____________________ Group #: _____________________________

Insurance Address: _____________________________ City: _______________________ State: ________ Zip: ____________________

Secondary Insurance Information (if applicable)

Name of Insurance: ____ Effective Date: _____/_____/_________

Policy Holder's Name: ___________________ Relation to Patient: ________________ Policy Holder's D.O.B.: ____/____/___________

Policy Holder's S.S. #: ____________________________ Policy #: _____________________ Group #: _____________________________

Insurance Address: _____________________________ City: _______________________ State: __________ Zip: __________________

I authorize Avina Women's Care and any entity authorized by my healthcare provider to contact me by using any telephone number, email address and mailing address provided. I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to Avina Women's Care. By signing this form, I agree to be fully responsible for payment of services deemed medically unnecessary or are not covered by my insurance carrier.

Patient Signature: ____ Date: ______________________

(Parent/Guardian Signature, if applicable)