Patient Demographic Form

avina women's care™

Patient Information

Last Name: _____ First Name: _____ Middle Name: _____

Maiden Name: _____ Date of Birth: _____ /_____ /_____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

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

Preferred Language: _____

Preferred Pharmacy: _____ Phone #: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

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)