Damien Fertility Partners
Regional Women's Health Group, LLC

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:_____
Address (street): _____ City, State, Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Referring Physician: _____ Telephone #: _____
Address (street): _____ City, State, Zip: _____

Employer Information

Employer: _____
Employer Address (street): _____ City, State, Zip: _____

Emergency Contact Information

Emergency Contact: _____ Relationship to You: _____
Home Phone: _____ Alt. Phone: _____

Insurance Information

PRIMARY CARRIER: _____ Telephone #: _____
Address: _____ City, State, Zip: _____
ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____
SECONDARY CARRIER: _____ Telephone #: _____
Address: _____ City, State, Zip: _____
ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____
Are you covered under your partner's insurance: _____ Yes _____ No
Participating Lab / Hospital: _____

Partner Information

Last Name: _____ First Name: _____ Date of Birth:_____

Partner Insurance Information

PRIMARY CARRIER: _____ Telephone #: _____
Address: _____ City, State, Zip: _____
ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____
SECONDARY CARRIER: _____ Telephone #: _____
Address: _____ City, State, Zip: _____
ID/Cert #: _____ Group/Plan #: _____ Effective Date: _____
Are you covered under your partner's insurance: _____ Yes _____ No
Participating Lab / Hospital: _____

Parent / Guardian Information

Contact: _____ Relationship to You: _____
Home Phone: _____ Alternate Phone: _____
Contact: _____ Relationship to You: _____
Home Phone: _____ Alternate Phone: _____

Electronic Communication (as of December 1, 2015)

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, my email is provided below.

Home Email: _____

☐ No, I do not wish to participate at this time.

_____ _____

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 for services relating to my medical care, including monies I may owe, I agree that Regional Women's Health Group, LLC and/or your agents may contact me by telephone, including 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 want to participate, my cell number is provided below.

Cell Phone Number:

☐ No, I do not wish to participate at this time. I would prefer to be notified by:

☐ Mail ☐ Telephone ☐ e-mail (via the Portal – you will need to participate, see above.)

Additional Information

Race: Which category best describes your racial background? (Choose all that apply)

☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Asian ☐ White

☐ Black or African American ☐ Unreported/Refused to Report

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

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unreported/Refused to Report

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

☐ English ☐ Spanish ☐ Other _____

How did you hear about our practice? ☐ Health Plan ☐ Internet _____ ☐ Our Web Site ☐ ER/Hospital ☐ Newspaper/Magazine _____ ☐ Patient _____ ☐ 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