

**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