ADVANCED GYNECOLOGY AND WELLNESS

PATIENT DEMOGRAPHICS

Patient Information

Last Name: **First Name:** **M.I.:**

Preferred Name: **Date of Birth:**

Address:

City: **State:** **Zip:**

Contact Information

Phone: **Is this a mobile number?** ☐ **Yes** ☐ **No**

Do you consent to receive text messages from Advanced Gynecology and Wellness, PA regarding appointments, care coordination, and practice-related communications at this number? ☐ **Yes** ☐ **No**

Message and data rates may apply. You may opt out at any time by notifying the office.

Email Address:

Do you consent to receive non-urgent communications from Advanced Gynecology and Wellness, PA at this email address (e.g., scheduling, forms, general updates)? ☐ **Yes** ☐ **No**

Gender & Identity

Sex Assigned at Birth: ☐ **Female** ☐ **Male** ☐ **Prefer not to answer**

Pronouns (optional): **Preferred Language:**

Insurance — Primary

Carrier Name: **Group Number:**

ID Number: **Relationship to Subscriber:**

Subscriber Name (if not self): **Subscriber DOB:**

Subscriber Address (if not self):

Insurance — Secondary (if applicable)

Carrier Name: **Group Number:**

ID Number: **Relationship to Subscriber:**

Pharmacy

Pharmacy Name:

Pharmacy Address:

Do you authorize Advanced Gynecology and Wellness, PA to electronically send prescriptions?

☐ **Yes** ☐ **No**

Emergency Contact

Name: **Phone:**

Relationship to Patient:

This individual will only be contacted in the event of an emergency and is not authorized to receive medical information unless otherwise permitted by law.

Patient Signature **Date**

By signing, I acknowledge the accuracy of the information provided above.