Axia WOMEN'S HEALTH

227 Laurel Road
Echelon One, Suite 300
Voorhees, NJ 08043
P (856) 669-6050

450 Cresson Blvd
Suite 300
Oaks, PA 19456
P (484) 831-0200

Riverview Women's Health
an Axia Women's Health Care Center

HIPAA & REGISTRATION UPDATE FORM

(Please Print)

Date / /	Primary Care Phys. (PCP):	PCP Phone No.:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	Gender: F M	Marital Status (circle one): Single / Mar / Div / Sep / Widow

Birth Date: / /	Age:	Social Security No.:	Home Phone No.: ( )	Cell Phone No.: ( )

Street Address:	City:	State:	Zip Code:

I authorize messages with medical information to be left on voicemail/answering machine at (check all that apply) ❑ Home ❑ Cell above.
I authorize: ❑ Brief message details to be left ❑ Extended message details to be left ❑ Restrictions:

PHARMACY INFORMATION

Local Pharmacy:	Address:	City:	State:
Mail-Order Pharmacy:	Address:	City:	State:

INSURANCE INFORMATION

Please give your insurance card(s) to the receptionist.

Name of Primary Insurance Company:	Subscriber's Name:	Subscriber's SSN:	Subscriber's Date of Birth: / /

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Partner ❑ Other – please explain:

Name of Primary Insurance Company:	Subscriber's Name:	Subscriber's SSN:	Subscriber's Date of Birth: / /

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Partner ❑ Other – please explain:

IN CASE OF EMERGENCY

Name of contact:	Relationship to patient:	Home Phone No.: ( )	Cell Phone No.: ( )

RELEASE OF MEDICAL AND BILLING INFORMATION

I authorize the following individual(s) to receive information pertaining to any medical history, treatment received and billing matters:

Name:	Relationship to patient:	Birth Date: / /	Contact Phone: ❑ Home ❑ Cell ( )
		/ /	( )

PATIENT PORTAL COMMUNICATION

We continue to 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 provided that we maintain your most up-to-date information. ***Do you wish to either continue to participate or sign up to participate?***

❑ Yes, I want to participate, my email is _____ ❑ No, I do not want to participate at this time.

MEDICAL CHAPERONE

I request a female chaperone to be present during my examination. ❑ Yes ❑ No ❑ Other (family member, partner, etc. will be present)

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my provider or insurance company to release any information required to process my claims.

_____ _____

Patient Signature *Date*