CHOICES.
Memphis Center for Reproductive Health

Name: _____
Patient No: _____
Date: _____
DOB: _____

DEMOGRAPHIC FORM

All patient information is confidential. Please print clearly in black ink.

Name: _____Preferred Pronoun: She/He/ They/Them/Theirs/Ze/Hir

Preferred Name:_____ DOB:_____ Home Phone_____ Cell_____

Where can we leave a message for you? Home/ Cell/ No Message / Leave me a message with:_____

Mailing Address: _____
Street Address City County State Zip

Email Address: _____ Would you like to be added to our mailing list? **Yes No**

Would you like to enroll in our electronic records Patient Portal which will enable you to receive your test results, communicate with provider, and access your health information directly via HIPPA secure site today? **Yes No**

Occupation: _____ Social Security Number: _____--____--_____

Emergency Contact Name: _____ Phone Number: _____

Relationship to you: _____ Does this person know you are here? **Yes No**

Who is here with you today? _____

Have you been a patient at CHOICES before? **Yes No** If yes, when? _____

Has your medical history changed since your last visit? **Yes No** If yes, please explain_____
_____

Do you have a primary physician? **Yes No** If yes, Name and Number: _____

Preferred Pharmacy Name: _____ Preferred Pharmacy Address: _____

Preferred Pharmacy Phone Number: _____

Do you have health insurance? **Yes No** Do you have secondary health insurance? **Yes No**

Name of Insurance: _____ Name of Insured: _____

SSN of Insured: _____--____--_____ DOB of Insured: _____

Member ID Number: _____ Group Number: _____

Relationship Status: _____ Highest Grade Completed: _____

Race: African American Caucasian Asian Native American Other: _____

Ethnicity: Hispanic Non-Hispanic

Gender: Male Female Non-binary Are you transgender? **Yes No** If yes, **MTF** or **FTM**

How did you hear about CHOICES? Web Search/Memphis Flyer/La Prensa /Memphis Magazine/ Other: _____

According to Chapter 1200-8-13 "Standards for Ambulatory Surgical Treatment Centers" for the State of Tennessee any adult or emancipated minor may execute an advance for directive health care. Would you like to execute an advance directive for health care today? **Yes No** Patient Initial: _____ Date: _____
Are you a registered Organ Donor? **Yes No**

I understand I am financially responsible for any services I receive during my visit to CHOICES, regardless of whether or not my procedure is able to be completed in its entirety. These services include, but are not limited to:

- Ultrasound testing
- Laboratory Testing
- Patient Education, and
- Consultation with CHOICES Clinician

Fees for services are based on CHOICES current fee schedule. No refunds will be made for services performed.

Patient Signature: _____ Date: _____