Physicians for Women
4660 Kenmore Avenue, Suite 1100
Alexandria, VA 22304

Name: ______________________ DOB: ______________

In an effort to better serve you, please choose the best method for both **Medical Information Left /Appointment Confirmation** and let us know if a detailed message can be left for that communication.

Please Check Any and All that apply:

☐ Phone Phone Number:_Cell or Land ______________________

☐ Text Cell Phone: ______________________

☐ Email Email Address: ______________________

**** Emergency Contact Name and Best # to reach them:** ______________________

We are now required to collect preferred language, race and ethnicity. If you prefer not to report this information you may choose to decline. Thank you for your cooperation.

Preferred Language	Race	Ethnicity
☐ English	☐ Asian	☐ Hispanic/Latino
☐ Spanish	☐ Black or African American	☐ Not Hispanic or Latino
☐ Other: ______________ (Please Indicate)	☐ American Indian/Alaskan Native	☐ Decline to Report
☐ Decline to Report	☐ Pacific Islander/Native Hawaiian	
	☐ White	
	☐ Other	
	☐ Unknown	
	☐ Decline to Report	

There is an option to collect your medication refill history through your pharmacy benefit plan (if you have one). Do you consent to allow us to obtain your medication history electronically?

☐ **Yes, you may obtain my medication history.** ☐ **No, I decline to participate.**

In an effort to better serve you, we would like to update your preferred pharmacy information. This information will be used to electronically prescribe your medications.

Pharmacy Name: ______________________

Address: ______________________

Patient Signature: ______________________ Date ______________