OB/GYN
ASSOCIATES OF ERIE

PLEASE PRINT

PATIENT REGISTRATION FORM

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Patient Date of Birth: _____ Social Security #: _____

Any Previous Last Names: _____

Employer: _____

Email Address: _____ (required for Portal Access)

Patient Family Doctor: _____

Cell Phone Number: (_____) - _____ - _____

Home Phone Number: (_____) - _____ - _____

Which method of contact would you prefer for appointment reminders?
We suggest choosing only one, but you may select multiple if desired.

☐ E-mail
☐ Text Message
☐ Phone Call to Cell Phone
☐ Phone Call to Home Phone

Note: If none of the above are selected, the contact method will default to a Phone call to your Home Phone if available.

Please check the identification group(s) that best applies to you. Check all that apply (optional):

Race

☐ White ☐ Black or African American ☐ Asian ☐ Other
☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Privacy Statement:

Your privacy is our utmost concern. In accordance with HIPAA regulation, we will keep your contact information private. This contact information will only be used by us to contact you for purposes pertaining to your medical care, such as appointment reminders, office announcements, and lab results.