OGA Patient Registration Form

Patient Information

Patient Name:_____
Last First MI Preferred/Nickname
Date of Birth:_____ Social Security #:_____
Street Address:_____
City: _____ State: _____ Zip Code:_____
Home Phone: _____Cell Phone: _____Work Phone:_____
Email:_____ Preferred Method of Contact: Home Cell Work Portal

Language: English Spanish Other_____Referring or Family/Primary Provider:_____
Race: Asian Black Hispanic/Latinx Indigenous Middle Eastern Other BIPOC Pacific Islander White Other Decline
Ethnicity: Asian Black Indigenous(American native) Mixed Ethnicity Pacific Islander White Decline
Marital Status: Married Single Divorced Widow Separated Partner

Preferred Pharmacy_____
Pharmacy Address City

Employed: Yes No Employer:_____Occupation:_____

EMERGENCY CONTACT: _____
RELATIONSHIP:_____Phone:_____
Cell Home

Guarantor Information *(only needed if patient under age 18 or NOT the guarantor/policy holder)*

Guarantor Name :_____Date of Birth: _____
Last First
Mailing Address :_____Relationship to Patient:_____
City:_____ State: _____Zip Code:_____
(Optional) Social Security #::_____ Phone:_____
Email: :_____

Would you like access to your account online with Patient Portal? *(we recommend this as an easy and secure way to contact the practice, review test results, or check payments)* Yes No

Do you prefer to receive your appointment reminder call by: Email & Phone (default) Phone No automated calls

I hereby confirm the above information is accurate and true.

_____
Signature Date

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