erie New Patient Registration

PATIENT INFORMATION

Last Name: ______________________________ Date of Birth (MM/DD/YYYY): ______________

First Name: ______________________________ Sex Assigned at Birth: ☐ Female ☐ Male

Middle Name: ______________________________ Preferred Name: ______________________

Street Address: ____

City/State/Zip: ____

Currently lack secure housing/homeless ☐ Yes ☐ No Migrant/seasonal worker ☐ Yes ☐ No

Primary Phone: (________) ______________________ ☐ Mobile ☐ Home ☐ Work ☐ Other

Secondary Phone: (________)______________________ ☐ Mobile ☐ Home ☐ Work ☐ Other

Email: ____

Communication Preferences

Best way to contact you (check all boxes that apply): ☐ Cell Phone ☐ Home Phone ☐ MyChart

Is it okay to leave phone messages? ☐ Yes ☐ No

Is it okay to receive text messages? ☐ Yes ☐ No

Is it okay to receive email? ☐ Yes ☐ No

Is it okay to receive mailings? ☐ Yes ☐ No

(Please note checking no means you will not receive appointment confirmations or reminders. If boxes above are not marked, we will assume that it is okay to use any of the methods above.)

Ethnicity:

☐ Cuban ☐ Mexican, Mexican American, or Chicano ☐ Puerto Rican ☐ Other Hispanic, Latino, or Spanish Origin
☐ Not Hispanic or Latino ☐ Unknown ☐ Prefer not to answer

Race (check all races that apply):

☐ Alaska Native ☐ American Indian ☐ Black or African American ☐ Asian Indian ☐ Chinese ☐ Filipino
☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Samoan ☐ Vietnamese
☐ Other Asian ☐ Other Pacific Islander ☐ White ☐ Unknown ☐ Prefer not to answer

Sexual Orientation:

☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Pansexual ☐ Omnisexual ☐ Asexual
☐ Queer ☐ Something Else ☐ Do not know ☐ Prefer not to answer

Gender Identity:

☐ Female ☐ Genderqueer ☐ Male ☐ Non-binary ☐ Trans Female (Male-to-Female)
☐ Trans Male (Female-to-Male) ☐ Two Spirit ☐ Questioning ☐ Other ☐ Prefer not to answer

Pronouns:

☐ She/Her ☐ He/Him ☐ They/Them ☐ Ze/Hir ☐ Ey/Em ☐ Xe/Xem ☐ Ve/Vir
☐ Patient's Name ☐ Other ☐ Prefer not to answer ☐ Do not know

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Patient Assistance

We want to make sure you have the support you need during your visit today. Please let us know if you are impacted by any of the following (check all that apply):

Preferred Language: ☐ English ☐ Spanish ☐ Other: ______________________________

Needs interpreter: ☐ Yes ☐ No

Low Vision: ☐ Yes ☐ No

Hard of Hearing: ☐ Yes ☐ No

Accessibility Needs: ☐ Cane ☐ Crutches ☐ Wheelchair ☐ Walker ☐ Patient Lift ☐ Elevator

Military Status: ☐ Veteran ☐ Active Military ☐ No military experience

Preferred Pharmacy: ______________________ Address: ______________________

Other things we should know to help us care for you during visit: ______________________

____

Emergency Contact Name: ______________________________

Phone: ______________________________

Relationship to Patient: ______________________________

Are you an employee of Erie? ☐ Yes ☐ No

Is your parent or spouse an employee of Erie? ☐ Yes ☐ No

Guarantor. This is the person responsible for bills:

Name: ______________________ Date of Birth: ______________________

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent/Guardian ☐ Other

Guarantor Preferred Language: ☐ English ☐ Spanish ☐ Other: ______________________

Family Size (Total Number of People Living in your House): ______________________

Average Annual Family Income: $ ______________________

Insurance Information*

Insurance/Policy Holder Name: ______________________ Date of Birth: ______________________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent/Guardian ☐ Other

Insurance (check what applies): ☐ Medicaid ☐ Medicare ☐ Commercial Insurance ☐ Other ☐ No Insurance

Insurance Plan: ______________________ Policy Number: ______________________

Group #: ______________________

*All patients, including those with insurance, may be eligible for Erie's Sliding Fee Scale Discount program.
If you selected Erie's Sliding Fee Scale Discount Program you must complete the Sliding Fee Scale Discount Program Application.