Welcome to Dr. Ben-Yehuda's Office

CONFIDENTIAL REGISTRATION FORM

Patient Information

Today's Date______________

Name:____ I prefer to be called: _______________________

Address:____City:_____________State:________Zip_______________

What is your current age: _________ Date of birth:______________ Birth place: __________________

Employer: ____________________________________ Occupation: __________________________________

Social Security number: _____________________

Religion: ____________________ (we ask for this because some heritable genetic diseases are associated with certain religious backgrounds.)

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Spouse's name:_____________________________ Employer____________________ Work phone______________

Spouse's date of birth: _____________________ Spouse's social security #: ________________________________

Whom may we thank for referring you? ____

Section II **Preferred Communication**

Phone (______)________________ Work Phone (_____) _______________ Cell Phone (______)___________________

To respect your privacy, please indicate which number we should use for appointment reminders, lab results, etc:

Please check the number we should use for this purpose: ☐ Home phone ☐ Work phone ☐ Cell phone

Is it ok to leave personal information? ____

Email: ___________________________________ Would you like to receive our quarterly e-newsletter? ☐ Yes ☐ No

Person to contact in case of emergency_________________________________ Phone________________________

Ohad Ben-Yehuda, M.D.
Fellow American College of Obstetrics & Gynecology