Porter Physician Group

Patient Name ____

Last *First* *Middle Initial* *Date of Birth*

Street Address ____

City ______________________ State _______ Zip Code ____________ Gender: F M

__________ / __________ / __________ Social Security # ________________

Home Phone *Cell Phone* *Work Phone*

Marital Status: S M W D Sep

Family Physician ______________________ Referring Physician______________________

Email Address: ____

Emergency Contact: ____

Name *Relationship* *Phone Number*

If patient is not the guarantor, please complete:

Guarantor ______________________________ Date of Birth ________________

Address ______________________ City/State/Zip ______________________

__________ / __________ / __________ Social Security # ________________

Home Phone *Cell Phone* *Work Phone*

You will be required to present your insurance card and photo ID at every visit.

	Primary Policy Holder	Secondary Policy Holder
Name		
Address		
City		
State,Zip		
Phone Number		
Gender (M or F)		
Date of Birth		
Social Security #		
Relationship to Patient		
Insurance Company		
Employer		

Race: White African American Asian American Indian Other: ________________ Decline ___

Language: English Spanish French German Other: ________________

Ethnicity: Hispanic Non Hispanic or Latino Decline ___

Would you like to receive a patient satisfaction call regarding your visit? ___ **Yes** ___ **No**

Do you consent to receive artificial, prerecorded,or automated calls such as reminder calls on your mobile phone? ___ **Yes** ___ **No**

Do you consent to receive text messages? ___ **Yes** ___ **No**
(By selecting no, This does not exclude you from receiving your visit summary via text message)

Would you like us to report any immunizations you receive to the national database? ___ **Yes** ___ **No**

What is your preferred pharmacy?______________________________

Where is your preferred lab you normally have your blood work done at?______________________

Do you consent to have your medications retrieved electronically from your pharmacy? ___ **Yes** ___ **No**

I hereby confirm the above information is accurate and true.

____

Patient/Guarantor Signature Date

____

If not signed by patient, please print name of Guarantor