FAMILY RENEWED™
Dawn M. Porter, MD

NEW PATIENT REGISTRATION FORM

Today's Date:	PCP Name, Address and Phone:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status:

Is this your legal name?	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:
○ Yes ○ No					○ M ○ F

Address: [Address/ P.O Box, City, ST ZIP Code]

Social Security no.:	Home phone no.:	Cell phone no.:

Occupation:	School/Employer Name and Address:	School/Employer phone no.:

Race: ___ American Indian/Alaskan Native ___ Asian ___ Black ___ Hispanic ___ White ___ Hawaiian/Pacific Islander ___ Other_____

Ethnicity: ___ Hispanic/Latino ___ Mexican ___ Not Hispanic/Latino ___Other _____

Chose clinic because/referred to clinic by:
Other family members seen here:

Email Address:
Preferred Method of Contact:
___Cell Phone
___home phone
___email/mail
Is it ok to contact you by cell phone or email?
Cell: ___yes ___no Email: ___yes ___no

PARENT/GUARDIAN (1) INFORMATION

Parent/Guardian last name:	First:	Middle Initial:	Marital status:

Is this your legal name?	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:
○ Yes ○ No					○ M ○ F

Address:

Social Security no.:	Home phone no.:	Cell phone no.:

Occupation:	Employer:	Employer phone no.:

Email Address:

Custodial Agreement if applicable (Please provide legal documentation):

1670 Essex Way, Suite A101, O'Fallon, IL 62269
3636 S. Geyer Road, Suite 100, St. Louis, MO 63127
Phone: (314) 238-7240·Fax: (877) 300-4369·www.familyrenewed.com

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NEW PATIENT REGISTRATION FORM (CONT.)

Patient's last name: | First Initial:

PARENT/GUARDIAN (2) INFORMATION

Parent/Guardian last name:	First:	Middle Initial:	Marital status:

Is this your legal name?	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:
○ Yes ○ No					○ M ○ F

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Email Address:

Is it ok to contact you by cell phone or email? Cell ___ yes ___ no Email ___ yes ___ no

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Occupation:	Employer:	Employer address:	Employer phone no.:
Please indicate primary insurance:		Secondary Insurance:	

Patient's relationship to subscriber. ___ Self ___ Spouse ___Child (mother's insurance) ___ Child (father's insurance)
___ Stepson/Stepdaughter (Stepmother's insurance) ___ Stepson/Stepdaughter (Stepfather's insurance)

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to Secondary Insurance Subscriber:

Secondary Insurance Subscriber's name (if applicable):	Subscriber's name:	Group no.:	Policy no.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work/Cell phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize DAWN M. PORTER, MD or insurance company to release any information required to process my claims.

Patient/Guardian (1) signature Date

Patient/Guardian (2) signature Date

Witness Date

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