



NEW PATIENT REGISTRATION FORM Updated January 2018

Today's Date:		PCP Name, Address and Phone:			
PATIENT INFORMATION					
Patient's last name:		First:		Middle:	Marital status:
Is this your legal name? <input type="radio"/> Yes <input type="radio"/> No	If not, what is your legal name?	Former name:		Birth date:	Age: Sex: <input type="radio"/> M <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No	If not, what is your legal name?	Former name:		Birth date:	Age: Sex: <input type="radio"/> M <input type="radio"/> 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):					



FAMILY
RENEWED™
 Dawn M. Porter, MD

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? <input type="radio"/> Yes <input type="radio"/> No	If not, what is your legal name?	Former name:		Birth date:	Age:	Sex: <input type="radio"/> M <input type="radio"/> 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		

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