

Porter Physician Group

Patient Name _____
Last First Middle Initial Date of Birth

Street Address _____

City _____ State _____ Zip Code _____ Gender: F M

Home Phone / Cell Phone / Work Phone Social Security # _____

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 _____

Home Phone / Cell Phone / Work Phone Social Security # _____

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?
 (By selecting no, This does not exclude you from receiving your visit summary via text message) ___ Yes ___ No

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