John R. Porter, MD, PA 1112 N. Floyd Rd, Ste. 10, Richardson, TX 75080 (972) 235-6911

New Patient Registration Form

Date: _____

*Indicates required fields

Our Electronic Medical Records require the following information in its entirety to successfully file your child's chart.

PATIENT INFORMATION

*First Name: _____ MI: _____ *Last Name: _____

*Date of Birth: _____ Nickname: _____

*Gender Assigned at Birth: ☐M ☐F Gender Identity (*if different than "at birth"):* _____

*Street Address: _____

*City: _____ State: _____ Zip: _____

*Primary Phone: _____ Phone #: _____

PHARMACY INFORMATION

*Preferred Pharmacy: _____ Phone #: _____

*Street Address: _____

*City: _____ State: _____ Zip: _____

SIBLING INFORMATION

Please list all siblings

Full Name:	DOB:	Gender:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

INSURANCE POLICY HOLDER INFORMATION
This information is required. If you don't have insurance, leave this blank.

*First Name: _____ *Last Name: _____

*Date of Birth: _____ Relationship to Patient: _____

☐ Address same as patient.

***OR:**

*Street Address: _____

*City: _____ State: _____ Zip: _____

*Employer: _____ *Insurance Company: _____

***Insurance Claims Mailing Address:**

*Street or P.O. Box: _____

*City: _____ State: _____ Zip: _____

*Policy / ID#: _____ Group #: _____

PARENT/GUARDIAN INFORMATION
*Do all parents and/or legal guardians reside with the patient, in the same household, together? □ Yes □ No

Parent/Guardian #1

*First Name: _____ *Last Name: _____

*Relationship to Patient: _____ *Are you a legal guardian to the patient? ☐Yes ☐No

*Date of Birth: _____ Gender: _____ Email: _____

*Primary Phone: _____ Other Phone: _____

Parent/Guardian #2

*First Name: _____ *Last Name: _____

*Relationship to Patient: _____ *Are you a legal guardian to the patient? □Yes □No

*Date of Birth: _____ Gender: _____ Email: _____

*Primary Phone: _____ Other Phone: _____