Porter Regional Hospital

85 East US 6 Frontage Road
Valparaiso, IN 46383
219-983-8300

***Required field** ****Insurance information must be provided or patient will be billed directly.**

Demographics:

*Name _____
Last First Middle Initial

*Gender: ❒ Male ❒ Female

*Date of birth ____/____/____

*SSN _____

Maiden Name _____

Other name(s) _____

*Address _____

*City/State _____ *Zip Code _____

*County _____

*Telephone # _____

Work # _____ Cell # _____

*Marital Status _____

Religion _____ Race _____

Physician Information:

*Today's Dr. _____

*Family Dr. _____

Patient's Employment Information:

Employer _____

Address _____

City/State _____ Zip Code _____

Occupation _____

Status ❒ Full-time ❒ Part-time

Emergency Contact:

Name _____
Last First Middle Initial

Address _____

City/State _____ Zip _____

Telephone # _____

Work # _____ Cell # _____

Relationship to Patient _____

Do you have an Advance Directive? ❒ Yes ❒ No

Is it on file? ❒ Yes ❒ No

Was the Hospital policy explained? ❒ Yes ❒ No

Primary Insurance:
****(Please complete or provide copy of card(s))**

*Name of Ins. Company _____

*Policy Owner _____

*SSN _____ *Date of birth _____

*Relationship to Patient _____

*Policy # _____ *Group # _____

Secondary Insurance:

Name of Ins. Company _____

Policy Owner _____

SSN _____ Date of birth _____

Relationship to Patient _____

Policy # _____ Group # _____

Guarantor/Person Responsible for Bill:

❒ Check here if same as patient

*Name _____
Last First Middle Initial

*Date of Birth ____/____/____

* Gender: ❒ Male ❒ Female

*Address _____

*City/State _____ *Zip Code _____

*Telephone _____ *SSN _____

*Relationship to Patient _____

Guarantor Employment:

Employer _____

Address _____

City/State _____ Zip Code _____

Telephone _____

Occupation _____

Status ❒ Full-time ❒ Part-time

PRH Use Only – Please Circle

LAB BBY OBG PT OT SGPT SGOT

Other _____ Initials _____

Date _____ Time _____

Scratch Sheet