RIVERSIDE MEDICAL CLINIC

Patient Information Sheet

☐ New Patient ☐ Insurance Change
☐ Name Change ☐ Other _____
☐ Address Change

New patients: Please complete all sections
Existing patients: Please complete Patient Information and any other changed information noting change in box on right.

PATIENT INFORMATION

Last Name	First Name	M.I.	Social Security No.	Sex ○M ○F	Date of Birth

Address	Apt. No.	City	State	Zip Code

Contact Numbers **Check Primary**	Home Phone ☐	Work Phone ☐	Mobile Phone ☐	E-mail Address

Marital Status ○S ○M ○D ○W	Primary Language	Interpreter Required? ○Y ○N	Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Unknown ☐ Decline to Provide

Race: ☐ White ☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Unknown ☐ Decline to Provide

PRIMARY CARE PROVIDER INFORMATION

Name	Address	Phone	Fax

EMERGENCY CONTACT INFORMATION

Name	Relationship	Is this the patient's legal guardian? ○Y ○N	Contact # ☐ Home ☐ Work ☐ Mobile

Address	Apt. No.	City	State	Zip Code

EMPLOYER INFORMATION

Name	Work #	Contact Person:	Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Student ☐ Unemployed

Address	Suite No.	City	State	Zip Code

GUARANTOR/FINANCIAL RESPONSIBILITY INFORMATION (COMPLETE ONLY IF DIFFERENT THAN PATIENT)

Must be completed if patient is a minor

Relationship to patient: ☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Other: (explain)

Last Name	First Name	M.I.	Social Security No.	Sex ○M ○F	Date of Birth

Address (If different than Patient's)	Apt. No.	City	State	Zip Code

Contact Numbers **Check Primary:**	Home Phone ☐	Work Phone ☐	Mobile Phone ☐	E-mail Address

EMPLOYER INFORMATION

Name	Work #	Contact Person:	Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Student ☐ Unemployed

Address	Suite No.	City	State	Zip Code

INSURANCE INFORMATION

PATIENTS PRIMARY INSURANCE

Name	Address	Phone	Auth Phone #

Group Number	Member ID #	Member Effective Date	Covered Through: ☐ Current Employment ☐ Cobra ☐ Retirement

SUBSCRIBER INFORMATION

Patients Relationship to Subscriber of Insurance: ☐ Husband ☐ Wife ☐ Child ☐ Other	Subscribers ID #

Subscriber Last Name	First Name	M.I.	Social Security No.	Sex ○M ○F	Date of Birth

Address (If different than Patient's)	Apt. No.	City	State	Zip Code

Subscribers Employer Name	Phone #	Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Student ☐ Unemployed

PATIENTS SECONDARY INSURANCE

Name	Address	Phone	Auth Phone #

Group Number	Member ID #	Member Effective Date	Covered Through: ☐ Current Employment ☐ Cobra ☐ Retirement

SUBSCRIBER INFORMATION

Patients Relationship to Subscriber of Insurance: ☐ Husband ☐ Wife ☐ Child ☐ Other	Subscribers ID #

Subscriber Last Name	First Name	M.I.	Social Security No.	Sex ○M ○F	Date of Birth

Address (If different than Patient's)	Apt. No.	City	State	Zip Code

Subscribers Employer Name	Phone	Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Student ☐ Unemployed

ACCIDENT INFORMATION

Is today's visit accident related? ○No ○Yes If Yes, Kind of Accident: ☐ Work ☐ Auto ☐ Other (explain):_____

Please give a brief description of the accident:

NEAREST RELATIVE NOT LIVING WITH YOU

Name	Relationship	Contact # ☐ Home ☐ Work ☐ Mobile

Address	Apt. No.	City	State	Zip Code

HOW DID YOU HEAR ABOUT THE CLINIC

☐ Friend ☐ Family ☐ Magazine ☐ Newspaper ☐ Internet ☐ Radio ☐ TV ☐ Health Fair ☐ Open Enrollment ☐ Other

The above information is true and correct and completed by:

☐ Patient ☐ Parent ☐ Conservator ☐ Guardian (Print & Sign)	Relationship to patient	Today's Date
Print Name		

When presenting this form to the Reception area please have your identification and Insurance Card(s) available for scanning. Thank you for choosing Riverside Medical Clinic.

OFFICE USE ONLY

Medical Record #: _____