RIVERSIDE FAMILY MEDICINE

PATIENT INFO FORM

[PLEASE PRINT]

OFFICE USE ONLY			
NEW FM	NEW	INA	UPDATE

Today's Date ____/____/____

PATIENT'S NAME _____ **DATE OF BIRTH**_____ AGE _____
LAST FIRST MIDDLE

ADDRESS _____ **ZIP CODE**_____
STREET CITY

HOME PHONE _____ SSN ____-____-_____ SEX _____ MARITAL STATUS: *(Circle One)* S / M / W / D

EMPLOYER INFORMATION: PLACE OF EMPLOYMENT _____

ADDRESS _____ **WORK PHONE** _____

SPOUSE OR PARENT/GUARDIAN INFO:

NAME _____ **DATE OF BIRTH**_____ AGE _____
LAST FIRST MIDDLE

ADDRESS _____ **ZIP CODE**_____
STREET CITY

HOME PHONE _____ **SSN** ____-____-_____ **SEX** _____ **MARITAL STATUS: *(Circle One)* S / M / W / D**

EMPLOYER INFORMATION: PLACE OF EMPLOYMENT _____

ADDRESS _____ **WORK PHONE** _____

DEPENDENT INFORMATION: [continue on back of page if necessary]

Name					
DOB					
SSN					

INSURANCE INFORMATION (Please fill out completely, staff will also copy your card):

Primary:_____ **Secondary**:_____
Address: _____ Address: _____
City:_____St____Zip_____ City:_____St____Zip_____
Group Number:_____ Group Number:_____
Policy Number:_____ Policy Number:_____
Subscriber's Name:_____ Subscriber's Name:_____
Subscriber's Date of Birth:____/____/_____ Subscriber's Date of Birth: ____/____/_____
Relationship to Patient:_____ Relationship to Patient:_____

PERSON RESPONSIBLE FOR BILL (NOT INSURANCE COMPANY):

NAME _____ DATE OF BIRTH ____/____/_____

ADDRESS _____

SOCIAL SECURITY NO. ____-____-_____ HOME PHONE _____ RELATIONSHIP TO PATIENT _____

PLACE OF EMPLOYMENT _____ WORK PHONE NUMBER _____

PERSON TO NOTIFY IN CASE OF EMERGENCY: NAME: _____

DAYTIME PHONE: (____)____-_____ Date of Birth____/____/____ Relationship _____

I authorize treatment by Riverside Family Medicine. I agree to be responsible for my bill and 33 ⅓% collection or attorney fees incurred in the collection of any amount due to Riverside Family Medicine. I authorize the release of information to any agency involved in the payment of my treatment, or to any provider I am referred to for consultation and/or treatment. I agree to pay a $20.00 service charge if my check is returned for any reason whatsoever. I authorize my insurer to pay for services rendered by Riverside Family Medicine. **I HAVE RECEIVED THE RIVERSIDE POLICIES.**

_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE