RIVERSIDE MEDICAL CLINIC

Patient Information Sheet

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

OFFICE USE ONLY

Doctor #: _____
Account #: _____
Family Member #: _____
Medical Record #: _____

PATIENT INFORMATION

Last Name	First Name	M.I.	Sex (M or F)	Date of Birth	Social Security No.

Patient's Address	Apt. No.	City	State	Zip Code

Patient's Home Telephone	Work Phone	Message Phone	Marital Status (S, M, D, or W)

CIRCLE PRIMARY CONTACT NUMBER

Patient's Employer	Employer's Street Address	City, State, Zip Code	Telephone

Language of Preference	Interpreter Required? ☐ Yes ☐ No	E-mail Address

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Unknown ☐ Decline to Provide

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

GUARANTOR/FINANCIAL RESPONSIBILITY INFORMATION (COMPLETE ONLY IF PATIENT IS A MINOR OR FULL-TIME STUDENT)

Father's Name (last, first, M.I.)	Father's Address (if different than patient's)

Father's Employer	Employer's Street Address	City, State, Zip

Father's Social Security No.	Date of Birth	Business Phone

Mother's Name (last, first, M.I.)	Mother's Address (if different than patient's)

Mother's Employer	Employer's Street Address	City, State, Zip

Mother's Social Security No.	Date of Birth	Business Phone

SPOUSE OR EMERGENCY INFORMATION

Last Name	First Name	Relationship to Patient	Telephone

INSURANCE INFORMATION

Primary Insurance Co.	Policy Number	Group Number	Plan Code

Subscriber Name	Date of Birth	Subscriber ID	Employer

Secondary Insurance Co.	Policy Number	Group Number	Plan Code

Subscriber Name	Date of Birth	Subscriber ID	Employer

DOES THE PATIENT HAVE ANY OTHER MEDICAL INSURANCE? IF YES, PLEASE COMPLETE BELOW:

Insurance Co.	Subscriber	Policy Number

NEAREST RELATIVE (NOT LIVING WITH YOU)

Relative's Name	Street Address	Phone Number

Missed appointments may be subject to a charge if 24 hour prior notice is not given.

All returned checks will be subject to a $20.00 processing fee. Failure to replace and pay all returned checks and the processing fee could result in the item being turned over to the District Attorney's Office.

My signature below hereby authorizes the above named insurance company(s) to pay for all medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance company. I authorize release of medical information to said insurance company. Additionally, my signature provides willing consent to the procedures which may be performed, including emergency treatment or services, and which may include but is not limited to, laboratory procedures, x-ray exams, medical or surgical treatment or procedures, anesthesia, vaccinations, or services rendered to the patient under the general and special instructions of the patient's physician or his designate.

Signature _____ Date _____ If Not Patient, Relationship _____

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

By signing this form, you are granting consent to Riverside Medical Clinic to use and disclose your protected health information for the purpose of treatment, payment and healthcare operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have the legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

You may obtain a copy of the Notice of Privacy Practices by viewing our website www.riversidemedicalclinic.com or by contacting our Quality Management Department at (951) 782-5103.

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

To request restrictions, you must make your request in writing to Riverside Medical Clinic Medical Records Department at 3660 Arlington Avenue Riverside, CA 92506. Please tell us (1) What information you want to limit (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

Signature (Patient / Parent / conservator / guardian) Date