Riverside MEDICAL GROUP

Your family's complete medical home.

New Patient Registration Form

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Special Living Arrangements: ☐ None ☐ Assisted Living ☐ Nursing Home

Cell Phone: _____ Home Phone: _____

E-mail Address: _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American/Black

☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian

Ethnicity: ☐ Central/South America ☐ Cuban ☐ Mexican ☐ Puerto Rican

☐ Other Hispanic/Latino ☐ Non-Hispanic/Latino

Preferred Language: _____ Marital Status: _____

Employment: ☐ Employed ☐ Medical Disability ☐ Self-Employed ☐ Retired ☐ Unemployed

Employer: _____ Employer Address: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone Number: _____

Pharmacy: _____ Phone Number: _____

Referring Provider: _____ Phone Number: _____

I, _____ DOB _____

Received the Riverside Medical Group Notice of Privacy Practice. I have been informed that if I have any questions regarding Riverside Medical Group's Privacy Policy or do not understand any information in the Notice that I may direct these questions to the Privacy Officer.

_____ _____

Patient's Signature Date

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Primary Insurance

Name of Policy Holder/Guarantor: _____

Date of Birth: _____ Relationship to Patient: _____

Policy Holder/Guarantor's Address _____

Employment: ☐ Employed ☐ Medical Disability ☐ Self-Employed ☐ Retired ☐ Unemployed

Employer: _____ Employer Address: _____

Insurance Company: _____

Insurance Policy ID #: _____ Group #: _____

Insurance Claim Address: _____ Phone #: _____

Secondary Insurance

Name of Policy Holder/Guarantor: _____

Date of Birth: _____ Relationship to Patient: _____

Policy Holder/Guarantor's Address _____

Employment: ☐ Employed ☐ Medical Disability ☐ Self-Employed ☐ Retired ☐ Unemployed

Employer: _____ Employer Address: _____

Insurance Company: _____

Insurance Policy ID #: _____ Group #: _____

Insurance Claim Address: _____ Phone #: _____