riverside
women's care

Welcome to Riverside Women's Care

Thank you for selecting our practice! We will strive to provide you with the best possible healthcare. To help us meet your entire healthcare needs, please fill out this form completely in ink.

PATIENT INFORMATION (CONFIDENTIAL)

Name (as it appears on your insurance card)

Last _____ First_____ Middle _____

Maiden Name (if applicable) _____ Birth Date _____/ _____/ _____ (mm/dd/yyyy)

Social Security Number _____ Marital Status □ Single □ Married □ Other _____

Mailing Address (Street/PO Box) _____ (Apt #) _____

(City) _____ (State) _____ (Zip) _____

Home Number (_____) _____ Cell Number (_____) _____

Work Number (_____) _____ Email _____

Employer _____ Occupation _____

Race:
□ American Indian or Alaska Native
□ Asian
□ Native Hawaiian
□ Black or African American
□ White
□ Hispanic
□ Other Race _____

EMERGENCY CONTACT

Name _____ Relation to Patient _____

Home Number (_____) _____ Cell Number (_____) _____

Mailing Address (Street/PO Box) _____ (Apt #) _____

(City) _____ (State) _____ (Zip) _____

Primary Care Physician _____ Phone Number (_____) _____

Pharmacy Currently Using _____ Location _____

Riverside Women's Care | Initial Visit / New Patient Information, continued.

INSURANCE

Please provide information on all insurance policies under which you are covered. If you have multiple carriers, please make sure each carrier is aware of the other.
An insurance policy wherein the patient is the subscriber is always the PRIMARY.

PRIMARY INSURANCE INFORMATION

Insurance Carrier _____

Identification Number _____ Group Number _____

Insurance Claims Address _____

Insurance Telephone (_____) _____

Subscriber's Name _____

Social Security Number _____ Date of Birth _____/_____/_____(mm/dd/yyyy)

Relationship to Patient □ Self □ Spouse □ Mother □ Father □ Other _____

Subscriber's Address _____

SECONDARY INSURANCE INFORMATION

Insurance Carrier _____

Identification Number _____ Group Number _____

Insurance Claims Address _____

Insurance Telephone (_____) _____

Subscriber's Name _____

Social Security Number _____ Date of Birth _____/_____/_____(mm/dd/yyyy)

Relationship to Patient □ Self □ Spouse □ Mother □ Father □ Other _____

Subscriber's Address _____

RESPONSIBLE PARTY □ SELF □ SPOUSE □ OTHER _____

Last _____ First _____ Middle _____

Social Security Number _____ Birth Date _____/ _____/ _____ (mm/dd/yyyy)

Mailing Address (Street/PO Box) _____ (Apt #) _____

(City) _____ (State) _____ (Zip) _____

Home Number (_____) _____ Cell Number (_____) _____

Work Number (_____) _____ Email _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered accurately. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I authorize payment of medical benefits to **Riverside Women's Care** when assignment has been taken. I have read and agree to the office financial policy and agree to all terms and conditions and revisions of those terms and conditions. I authorize **Riverside Women's Care** to use or disclose any information for treatment, payment, and health care operations. I authorize that the physicians and/or employees of **Riverside Women's Care** can contact me via all electronic formats (such as telephone, email, fax, etc.) or leave me a message if they are unable to contact me directly. I have read or received a copy of the Notice of Privacy Practices.

Patient's Signature _____ Date _____

Guardian's Signature _____ Date _____

Guardian's Relationships _____ Date _____