**RIVERSIDE SURGICAL ASSOCIATES, INC.**
**PATIENT INFORMATION SHEET** Date_____

NAME _____ HOME PHONE NUMBER ( ) _____
LAST FIRST MIDDLE

ADDRESS _____ CELL PHONE NUMBER ( ) _____

CITY _____ STATE _____ ZIP CODE _____ MARITAL STATUS_____

DATE OF BIRTH _____ AGE _____ SS# _____ SEX: _____M _____F

PREFERRED LANGUAGE_____ RACE_____ ETHNICITY: □ Hispanic or Latino (or) □ Non-Hispanic or Latino

□ Retired (or) □ Actively Employed (check one) ☐ Full Time (or) ☐ Part Time Employed (check one) □ Full Time (or) □ Part Time Student (check one)

EMPLOYER _____ WORK NUMBER ( ) _____EXT#_____
(IF RETIRED LIST PREVIOUS EMPLOYER)

E-MAIL ADDRESS_____ PREFERRED METHOD OF CONTACT_____

SPOUSE OR PARENT'S NAME (circle one)_____ SPOUSE OR PARENT'S SS#_____

ABOVE PERSON'S EMPLOYER_____ ABOVE PERSON'S WORK# ( ) _____
EXT# _____

1-CONTACT PERSON'S NAME AND
RELATIONSHIP TO PATIENT _____PHONE# ( )_____
(OTHER THAN SPOUSE) Name of person with whom we may discuss your personal health information

HAVE YOU SEEN ANY OF THE PHYSICIANS IN OUR PRACTICE BEFORE? _____YES _____NO IF SO, WHEN? _____

REASON FOR SEEING THE DOCTOR _____

FAMILY DOCTOR_____ PHONE# ( ) _____
FIRST LAST

REFERRING DOCTOR_____ PHONE# ( ) _____
FIRST LAST

INJURY/ILLNESS DUE TO AUTO ACCIDENT _____YES _____NO INJURY/ILLNESS WORK RELATED _____YES _____ NO DATE OF INJURY_____

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PRIMARY INSURANCE NAME _____ PHONE# ( )_____

POLICY HOLDER'S NAME _____ RELATIONSHIP TO PATIENT _____

I.D.# _____ GROUP OR CONTROL NUMBER _____

POLICY HOLDER'S DATE OF BIRTH _____ CO-PAY (IF APPLICABLE)_____

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SECONDARY INSURANCE NAME _____PHONE# ( )_____

POLICY HOLDER'S NAME _____ RELATIONSHIP TO PATIENT _____

I.D.# _____ GROUP OR CONTROL NUMBER _____

POLICY HOLDER'S DATE OF BIRTH _____ CO-PAY (IF APPLICABLE) _____
(IF MORE THAN TWO INSURANCES, LIST ON BACK)

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**MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to the provider (Physician) for any services furnished me by that Physician. I authorize any holder of Medicare information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services. I hereby authorize Medicare to furnish to the above named Physician any information regarding my Medicare claims under Title XVIII of the Social Security Act. I understand that I am financially responsible for any balance not covered by my insurance carrier.

PATIENT'S SIGNATURE_____ DATE _____

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**COMMERCIAL INSURANCE:** I hereby authorize release of information to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE PHYSICIAN OR GROUP INDICATED ON THE CLAIM. I understand that I am financially responsible for any balance not covered by my insurance carrier.

PATIENT'S SIGNATURE _____ DATE_____