RIVERVIEW HEALTH PHYSICIANS

PATIENT INFORMATION

PATIENT NAME: PREFERRED (NICK) NAME: SEX:

BIRTH DATE: SOCIAL SECURITY #: PRIMARY CARE PHYSICIAN:

ADDRESS: CITY:

COUNTY: STATE: ZIP:

HOME PHONE: ( ) WORK: ( ) CELL: ( )

Circle One: Preferred Preferred Preferred

PREFERRED LANGUAGE: INTERPRETER NEEDED: Yes No

Circle One

MARITAL STATUS: Married-Single-Widowed-Divorced-Minor SPOUSE NAME & PHONE:

Circle One

RACE: Caucasian - African American - Hispanic - Asian - American Indian - Other ETHNICITY: Hispanic Non-Hispanic

Circle One Circle One

PREFERRED METHOD OF CONTACT: Phone - Postal Mail - My Chart E-MAIL:

Circle One: Preferred

EMPLOYER: EMPLOYMENT STATUS: Full-time Part-time Retired

Circle One

RESPONSIBLE PARTY DEMOGRAPHICS - PLEASE INDICATE IF SAME AS ABOVE AND DON'T DUPLICATE INFO.

RESPONSIBLE PARTY NAME: RELATION TO PATIENT:

ADDRESS: CITY:

COUNTY: STATE: ZIP:

SOCIAL SECURITY: SEX:

HOME PHONE: ( ) WORK: ( ) CELL: ( )

EMPLOYER: EMPLOYMENT STATUS: Full-time Part-time Retired

Circle One

SUBSCRIBER DEMOGRAPHICS - PLEASE INDICATE IF SAME AS ABOVE AND DON'T DUPLICATE INFORMATION

SUBSCRIBER NAME: RELATION TO PATIENT:

ADDRESS:

CITY: STATE: ZIP:

EMPLOYER: EMPLOYMENT STATUS: Full-time Part-time Retired

Circle One

PARENT/GUARDIAN/FAMILY INFORMATION (Complete for minor patients only)

MOTHER'S NAME:

HOME PHONE: ( ) WORK: ( ) CELL: ( )

Circle One: Preferred Preferred Preferred

FATHER'S NAME:

HOME PHONE: ( ) WORK: ( ) CELL: ( )

Circle One: Preferred Preferred Preferred

PATIENT'S PRIMARY RESIDENCE: (Circle One) Mother Father Both Other:

SIBLINGS:

NAME: AGE: SEX:

NAME: AGE: SEX:

NAME: AGE: SEX:

NAME: AGE: SEX:

UNINSURED

I do not have insurance and understand that I am financially responsible for the charges incurred.

Patient/Guardian Signature: Date:

WORKER'S COMPENSATION INSURANCE (If Applicable)

If your visit is related to a work injury please notify the receptionist and provide your employer information.

SIGNATURE OF INDIVIDUAL COMPLETING FORM

Signature: Date: