RIVERSIDE MEDICAL ARTS

Received and completed by _______

PATIENT INFORMATION

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Jr ☐ Sr ☐ II ☐ I

Sex: ☐ Female ☐ Male

Date of Birth: mm / dd / yyyy

First Name | Middle Initial | Last Name | Social Security Number - -

Physical Address | City | State | Zip

Mailing Address | City | State | Zip

Preferred Phone Number ( ) - | Home Phone Number ( ) - | Cell Phone Number ( ) - | Work Phone Number ( ) -

Email Address

Confidential Communication Preference: ☐ Email ☐ Letter ☐ Other __________________________ ☐ Patient Portal

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Unknown

Preferred Language

Ethnicity: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Unknown

Race: ☐ American Indian ☐ Asian ☐ Black /African American ☐ Native Hawaiian ☐ Other Pacifica Islander ☐ White ☐ Other

Employer Name

Preferred Provider: ☐ Benjamin G Carter, MD ☐ April A Larson, MD

PARENT / LEGAL GUARDIAN / LEGAL REPRESENTATIVE INFORMATION

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Jr ☐ Sr ☐ II ☐ I

Sex: ☐ Female ☐ Male

Date of Birth: mm / dd / yyyy

First Name | Middle Initial | Last Name | Social Security Number - -

Address | City | State | Zip | Email Address

Relation to Patient | Home Phone Number ( ) - | Cell Phone Number ( ) - | Work Phone Number ( ) -

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insurance Carrier Name		Insurance Carrier Name	
Group Name	Group Number	Group Name	Group Number
Subscriber Name		Subscriber Name	
Subscriber ID		Subscriber ID	
Subscriber Date of Birth	Relation to Patient	Subscriber Date of Birth	Relation to Patient
Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student		Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student	

SPOUSE OR EMERGENCY CONTACT

First Name | Last Name | Relation to Patient

Home Phone Number | Cell Phone Number

REFERRAL

How did you hear about our clinic?

Referred by

SIGNATURE

Signature of Patient or Legal Guardian

Date: mm / dd / yyyy

Patient Account # _________________

RIVERSIDE MEDICAL ARTS

Patient First Name	Patient Last name

Parent / Guardian Name	Relation to Patient

NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been offered / provided with a copy of Riverside Medical Arts Notice of Privacy Practices.

PATIENT RIGHTS AND RESPONSIBILITIES

My signature below indicates that I have been offered / provided with a copy of Riverside Medical Arts patient rights and responsibilities.

DISCLOSURE OF OWNERSHIP INTEREST

My signature below indicates that I have been offered / provided with a copy of Riverside Medical Arts disclosure of ownership interest.

LABORATORY

My signature below indicates I understand that all lab work ordered by my physician and sent to an outside lab will be billed separately by that lab to my insurance company. I understand that I am responsible to pay for all lab charges, whether or not I have insurance and whether or not it is a covered benefit of my insurance. I understand that the laboratory will bill me separately for these lab charges.

FINANCIAL RESPONSIBILITY / ASSIGNMENT OF BENEFITS / BILLING AGREEMENT

Insurance is a way for you to receive repayment for fees you have paid to a physician for services rendered. Having insurance is not a substitute for payment. Even though insurance companies have a fixed allowance or percentage based on your policy with them, your policy is with your insurance company, not with this office. It is your responsibility to provide payment for the deductible, co-insurance, and any other balances not paid for by your insurance. We will assist you in receiving reimbursement in any way possible, but you are ultimately responsible for the payment of your bill. Please provide complete insurance information to our office prior to your visit. If this information is not produced, payment for the services rendered will be due at the time of your visit. It is your responsibility to know the benefits provided by your insurance carrier. Please direct questions regarding your benefits to your insurance carrier or your human resources department. Riverside Medical Arts will make a reasonable attempt to inform you if your insurance is out of network. However, if your insurance is out of network you are responsible to pay for all services rendered. Payment in full will be due at the time of service if a particular service is not covered, we are unable to verify coverage, your coverage is pending or you are ineligible for coverage. Our office will file a claim with your primary insurance carrier. If a service requires additional information from the patient / guarantor, you are required to provide the necessary information to your insurance company or our office as soon as possible. If this information is not received by either the insurance company, or our office the payment for services rendered will then be the responsibility of the patient / guarantor. As a courtesy our office will file a claim with your secondary insurance company. If the services are unpaid by your secondary insurance carrier or require follow up, payment for services rendered are the responsibility of the patient / guarantor. In the event that your insurance company refuses payment for services rendered, you will be responsible for payment in full. A denial from your insurance company does not release you from your financial obligation to us. Payments on accounts billed are expected within 30 days of the statement date. A $25.00 returned check fee will apply for every returned check that is received by our office. Delinquent accounts will be charged interest at 1.5% per month. The undersigned specifically agrees to pay all reasonable attorneys' fees and court costs in the event legal action is taken to collect on an account. The undersigned further agrees to pay an additional amount representing up to 40% of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with the said collection action processing.

I hereby authorize the physician(s) of Riverside Medical Arts to release any information acquired in the course of my examination to my insurance company, another physician or hospital, adjuster or attorney. I authorize payment directly to Riverside Medical Arts for surgical and/or medical benefits, if any, otherwise payable to me for services as described. I understand that I am financially responsible for all charges whether or not paid by my insurance company. A photocopy of this assignment of benefits shall be considered as effective and valid as the original. I also authorize the physician to initiate a complaint to the insurance commissioner for any reason on my behalf. Any lab testing done in the office or outside laboratory will be billed separately by the laboratory. I consent to any medical treatment deemed medically necessary by the provider. I understand that these treatments will be discussed with me and all questions will be answered before it is rendered.

SIGNATURE

Signature of Patient or Legal Guardian	Date
	mm / dd / yyyy

Patient Account # ________________

RIVERSIDE MEDICAL ARTS

PATIENT HISTORY AND INTAKE FORM

First Name	Middle Initial	Last Name	Date of Birth mm / dd / yyyy

Preferred Pharmacy	Pharmacy Location
Primary Care Physician	**Primary Care Physician Phone Number**

PAST MEDICAL HISTORY (Please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Asthma
- ☐ Artrial fibrillation
- ☐ BPH
- ☐ Bone marrow transplantation
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes
- ☐ GERD
- ☐ End stage renal disease
- ☐ Hearing loss
- ☐ Hepatitis
- ☐ Hypertension/High Blood Pressure
- ☐ HIV /AIDS
- ☐ Hypercholesterolemia
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate cancer
- ☐ Radiation treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Valve replacement
- ☐ NONE
- ☐ Other ________________________
- ☐ Other ________________________

PAST SURGICAL HISTORY (Please check all that apply)

- ☐ Appendix removed
- ☐ Basal cell cancer
- ☐ Biological valve replacement
- ☐ Bladder removed
- ☐ Breast biopsy (right, left, bilateral)
- ☐ Breast implants
- ☐ Breast reduction
- ☐ Colectomy: Colon cancer resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: Irritable bowel disease
- ☐ Coronary artery bypass
- ☐ Gallbladder removed
- ☐ Heart transplant
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine cancer
- ☐ Joint replacement, hip (right, left, bilateral)
- ☐ Joint replacement, knee (right, left, bilateral)
- ☐ Joint replacement within last 2 years
- ☐ Kidney biopsy
- ☐ Kidney removed (right, left)
- ☐ Kidney stone removal
- ☐ Kidney transplant
- ☐ Lumpectomy (right, left, bilateral)
- ☐ Mastectomy (right, left, bilateral)
- ☐ Mechanical valve replacement
- ☐ Melanoma surgery
- ☐ Ovaries removed: Cyst
- ☐ Ovaries removed: Endometriosis
- ☐ Ovaries removed: Ovarian cancer
- ☐ Percutaneous transluminal coronary angioplasty (PTCA)
- ☐ Prostate biopsy
- ☐ Prostate removed: Prostate cancer
- ☐ Skin biopsy
- ☐ Spleen removed
- ☐ Squamous cell carcinoma surgery
- ☐ Testicles removed (right, left, bilateral)
- ☐ Transurethral resection of the prostate (**TURP**)
- ☐ NONE
- ☐ Other ______________________________________
- ☐ Other ______________________________________

PEDIATRIC HISTORY (For patients **2 years old and younger**)

Gestational Age at Birth	Birth weight	Forceps delivery
_______ weeks	________lbs ________oz	☐ Yes ☐ No

Maternal illness during pregnancy

SKIN CONDITIONS (Please check all that apply)

- ☐ Acne
- ☐ Allergies
- ☐ Asthma
- ☐ Basal cell skin cancer
- ☐ Blistering sunburns
- ☐ Dry skin
- ☐ Eczema
- ☐ Flaky itchy scalp
- ☐ Hay fever
- ☐ Melanoma
- ☐ Poison ivy
- ☐ Precancers
- ☐ Precancerous moles
- ☐ Psoriasis
- ☐ Squamous cell skin cancer

Other skin conditions:

Do you wear SPF (sun block)?	Do you tan in a tanning bed?
☐ Yes ☐ No If YES, what strength:	☐ Yes ☐ No If YES, how often:

Patient Account # ______________

RIVERSIDE MEDICAL ARTS

Is there a history of melanoma in your family? ☐ Yes ☐ No If YES, which family member:

CURRENT MEDICATIONS AND OVER THE COUNTER MEDICATIONS

Name of medication	Dose / Strength	Frequency	Date Started
Name of medication	Dose / Strength	Frequency	Date Started
Name of medication	Dose / Strength	Frequency	Date Started
Name of medication	Dose / Strength	Frequency	Date Started
Name of medication	Dose / Strength	Frequency	Date Started
Name of medication	Dose / Strength	Frequency	Date Started
Name of medication	Dose / Strength	Frequency	Date Started
Name of medication	Dose / Strength	Frequency	Date Started
Name of medication	Dose / Strength	Frequency	Date Started
Name of medication	Dose / Strength	Frequency	Date Started

ALLERGIES AND REACTIONS

Allergy	Describe Reaction	Allergy	Describe Reaction
Allergy	Describe Reaction	Allergy	Describe Reaction
Allergy	Describe Reaction	Allergy	Describe Reaction

SOCIAL HISTORY

Smoking/ Tobacco History
☐ Never smoked ☐ Quit – former smoker ☐ Smokes less than daily ☐ Smokes daily

Illicit Drug Use
☐ Drug use ☐ IV drug use ☐ None

Alcohol Use
☐ None ☐ Less than 1 drink a day ☐ 1 – 2 drinks a day ☐ 3 or more drinks a day

Safety
☐ I feel safe at home ☐ I do not feel safe at home

Other:

REVIEW OF SYMPTOMS (Please check all that apply)

☐ Abdominal pain
☐ Anxiety
☐ Bloody stool
☐ Bloody urine
☐ Blurry vision
☐ Chest pain
☐ Cough
☐ Depression
☐ Fever or chills
☐ Hay fever
☐ Headaches
☐ Immunosuppression
☐ Joint aches
☐ Muscle weakness
☐ Neck stiffness
☐ Night sweats
☐ Problems with bleeding
☐ Problems with healing
☐ Problems with scarring (hypertrophic or keloid)
☐ Chest Pains
☐ Rash
☐ Seizures
☐ Shortness of breath
☐ Sore throat
☐ Thyroid problems
☐ Unintentional weight loss
☐ Wheezing

Other symptoms:

ALERTS (Please check all that apply)

☐ Allergy to adhesive
☐ Allergy to lidocaine
☐ Allergy to topical antibiotics/ointments
☐ Artificial heart valve
☐ Artificial joint within past 2 years
☐ Blood thinners
☐ Breastfeeding
☐ Defibrillator
☐ MRSA
☐ Pacemaker
☐ Pregnancy or planning a pregnancy
☐ Premedication prior to procedures
☐ Rapid heartbeat with epinephrine

Other alerts:

Patient Account # ________________