

**PATIENT INFORMATION**

Title <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr <input type="checkbox"/> Jr <input type="checkbox"/> Sr <input type="checkbox"/> II <input type="checkbox"/> I				Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		Date of Birth mm / dd / yyyy	
Legal First Name		Middle Initial		Last Name		Nickname	
Social Security Number - -							
Mailing Address				City		State      Zip	
Home Phone Number (    ) -			Cell Phone Number (    ) -			Work Phone Number (    ) -	
Email Address				Confidential Communication Preference <input type="checkbox"/> Email <input type="checkbox"/> Letter <input type="checkbox"/> Other _____ <input type="checkbox"/> Patient Portal			
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown							
Preferred Language				Ethnicity		Race	
Employer Name							

**RESPONSIBLE PARTY INFORMATION**

Title <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr <input type="checkbox"/> Jr <input type="checkbox"/> Sr <input type="checkbox"/> II <input type="checkbox"/> I				Sex <input type="checkbox"/> Female <input type="checkbox"/> 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	

**EMERGENCY CONTACT**

Name		Relation to Patient		Phone Number	
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**DNR ORDER**

Do you have a DNR in place? ☐ Yes      ☐ No

**AUTHORIZATION TO RELEASE HEALTH INFORMATION TO:** (Example: Spouse/Partner, Parent, Child)

Name		Phone Number	
Dates of Service: From:                      To:		Authorization Expires (unless otherwise noted this authorization will remain in effect one year from the date signed) <input type="checkbox"/> Never      Date:	

**SIGNATURE**

Being the parent or legal guardian, I give Riverside Medical Arts permission to treat the above stated minor.

Signature of Patient or Legal Guardian		Date mm / dd / yyyy	
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Patient First Name	Patient Last name
Parent / Guardian Name	Relation to Patient
<b>NOTICE OF PRIVACY PRACTICES</b>	
My signature below indicates that I have been offered / provided with a copy of Riverside Medical Arts Notice of Privacy Practices.	
<b>PATIENT RIGHTS AND RESPONSIBILITIES</b>	
My signature below indicates that I have been offered / provided with a copy of Riverside Medical Arts patient rights and responsibilities.	
<b>DISCLOSURE OF OWNERSHIP INTEREST</b>	
My signature below indicates that I have been offered / provided with a copy of Riverside Medical Arts disclosure of ownership interest.	
<b>LABORATORY</b>	
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.	
<b>FINANCIAL RESPONSIBILITY / ASSIGNMENT OF BENEFITS / BILLING AGREEMENT</b>	
<p>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.</p> <p>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.</p>	

<b>SIGNATURE</b>	
Signature of Patient or Legal Guardian	Date <div style="text-align: right; margin-top: 10px;">mm / dd / yyyy</div>

**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)

<input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Artificial joints <input type="checkbox"/> Asthma <input type="checkbox"/> Atrial fibrillation <input type="checkbox"/> BPH <input type="checkbox"/> Bone marrow transplantation <input type="checkbox"/> Breast cancer <input type="checkbox"/> Colon cancer <input type="checkbox"/> COPD <input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> GERD <input type="checkbox"/> End stage renal disease <input type="checkbox"/> Hearing loss <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hypertension/High Blood Pressure <input type="checkbox"/> HIV /AIDS <input type="checkbox"/> Hypercholesterolemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Lymphoma <input type="checkbox"/> Pacemaker <input type="checkbox"/> Prostate cancer <input type="checkbox"/> Radiation treatment <input type="checkbox"/> Seizures <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Valve replacement <input type="checkbox"/> NONE <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____
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**PAST SURGICAL HISTORY** (Please check all that apply)

<input type="checkbox"/> Appendix removed <input type="checkbox"/> Basal cell cancer <input type="checkbox"/> Biological valve replacement <input type="checkbox"/> Bladder removed <input type="checkbox"/> Breast biopsy (right, left, bilateral) <input type="checkbox"/> Breast implants <input type="checkbox"/> Breast reduction <input type="checkbox"/> Colectomy: Colon cancer resection <input type="checkbox"/> Colectomy: Diverticulitis <input type="checkbox"/> Colectomy: Irritable bowel disease <input type="checkbox"/> Coronary artery bypass <input type="checkbox"/> Gallbladder removed <input type="checkbox"/> Heart transplant <input type="checkbox"/> Hysterectomy: Fibroids <input type="checkbox"/> Hysterectomy: Uterine cancer <input type="checkbox"/> Joint replacement, hip (right, left, bilateral) <input type="checkbox"/> Joint replacement, knee (right, left, bilateral) <input type="checkbox"/> Joint replacement within last 2 years <input type="checkbox"/> Kidney biopsy <input type="checkbox"/> Kidney removed (right, left)	<input type="checkbox"/> Kidney stone removal <input type="checkbox"/> Kidney transplant <input type="checkbox"/> Lumpectomy (right, left, bilateral) <input type="checkbox"/> Mastectomy (right, left, bilateral) <input type="checkbox"/> Mechanical valve replacement <input type="checkbox"/> Melanoma surgery <input type="checkbox"/> Ovaries removed: Cyst <input type="checkbox"/> Ovaries removed: Endometriosis <input type="checkbox"/> Ovaries removed: Ovarian cancer <input type="checkbox"/> Percutaneous transluminal coronary angioplasty (PTCA) <input type="checkbox"/> Prostate biopsy <input type="checkbox"/> Prostate removed: Prostate cancer <input type="checkbox"/> Skin biopsy <input type="checkbox"/> Spleen removed <input type="checkbox"/> Squamous cell carcinoma surgery <input type="checkbox"/> Testicles removed (right, left, bilateral) <input type="checkbox"/> Transurethral resection of the prostate (TURP) <input type="checkbox"/> NONE <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____
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**PEDIATRIC HISTORY** (For patients 2 years old and younger)

Gestational Age at Birth _____ weeks	Birth weight _____ lbs _____ oz	Forceps delivery <input type="checkbox"/> Yes <input type="checkbox"/> No
Maternal illness during pregnancy		

**SKIN CONDITIONS** (Please check all that apply)

<input type="checkbox"/> Acne <input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Basal cell skin cancer <input type="checkbox"/> Blistering sunburns	<input type="checkbox"/> Dry skin <input type="checkbox"/> Eczema <input type="checkbox"/> Flaky itchy scalp <input type="checkbox"/> Hay fever <input type="checkbox"/> Melanoma	<input type="checkbox"/> Poison ivy <input type="checkbox"/> Precancers <input type="checkbox"/> Precancerous moles <input type="checkbox"/> Psoriasis <input type="checkbox"/> Squamous cell skin cancer
Other skin conditions:		
Do you wear SPF (sun block)? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, what strength:	Do you tan in a tanning bed? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, how often:	

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)

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

### ALERTS

(Please check all that apply)

<input type="checkbox"/> Allergy to adhesive <input type="checkbox"/> Allergy to lidocaine <input type="checkbox"/> Allergy to topical antibiotics/ointments <input type="checkbox"/> Artificial heart valve <input type="checkbox"/> Artificial joint within past 2 years	<input type="checkbox"/> Blood thinners <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Defibrillator <input type="checkbox"/> MRSA <input type="checkbox"/> Pacemaker	<input type="checkbox"/> Pregnancy or planning a pregnancy <input type="checkbox"/> Premedication prior to procedures <input type="checkbox"/> Rapid heartbeat with epinephrine
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Other alerts: