Date _____
Account# _____
Referring Doctor _____

Arthritis Medical Clinic

(951) 781-7700 FAX (951) 781-0313
www.ArthritisMedicalClinic.org

OFFICE LOCATION
☐ 6180 Brockton Ave. Suite 204· Riverside, CA 92506
☐ 4244 Riverwalk Pkwy. #220, Riverside, CA 92505

Preferred Language: ☐English ☐Spanish **Race: _____ ☐Decline** **Ethnicity: ☐Hispanic ☐Non Hispanic**
Pharmacy: _____ **Tel: _____** **Fax: _____**

PATIENT'S PERSONAL INFORMATION

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Sex: ☐M ☐F

Name: _____ Email: _____

Street Address: _____ Apt #_____ City: _____ State: _____ Zip: _____

Cell # (____) _____ Home # (____) _____ Work # (____) _____ Social Security #_____-_____-_____

Date of Birth: _____/_____/_____ Driver's License (State) _____ (Number) _____

Employer / Name of School: _____ ☐Full Time ☐Part Time

Spouse's name:_____ Spouse's work phone: (_____) _____

Home phone: (____) _____ Work phone: (_____) _____ Social Security #_____-_____-_____

PATIENT'S RESPONSIBLE PARTY INFORMATION

Responsible party: _____ Date of Birth: _____

Relationship to Patient: ☐Self ☐Spouse ☐Other _____ Social Security #_____-_____-_____

Responsible Party's home phone: (_____) _____ Work phone: (_____) _____

Address: _____ Apt. #_____ City: _____ State: _____ Zip: _____

Employer's name: _____ Phone number: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Your occupation: _____

Spouse's Employer's name: _____ Spouse's Work phone: (_____) _____

Address: _____ Apt. #_____ City: _____ State: _____ Zip: _____

PATIENT'S INSURANCE INFORMATION

PRIMARY insurance company's name: _____

Insurance address: _____ City: _____ State: _____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured ☐ Self ☐ Spouse ☐ Other ☐ Child

Insurance ID number: _____ Group number: _____

SECONDARY insurance company's name: _____

Insurance address: _____ City: _____ State: _____ Zip: _____

Name of insured: _____ Date of Birth: _____ Relationship to insured ☐ Self ☐ Spouse ☐ Other ☐ Child

Insurance ID number: _____ Group number: _____

EMERGENCY CONTACT

Name of person not living with you _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: (_____) _____ Work phone: (_____) _____

Assignment of Benefits · Financial Agreement · Release of Medical Records

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Arthritis Medical Clinic, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I hereby authorize this healthcare provider to release medical records on the above patient. I further agree that a photocopy of this agreement shall be as valid as the original.

Date _____ Your Signature _____