Name:	DateAccount#Referring Doctor	(951) 781-7700	781-0313	OFFICE LOCATION ☐ 6180 Brockton Ave. Suite 204☐ Riverside, CA 92506 ☐ 4244 Riverwalk Pkwy. #220, Riverside, CA 92505						
Street Address:						_			_	
Cell # (
Date of Birth:	Street Address:		Apt #	City	·	State	:	_Zip:		
Employer / Name of School: Spouse's work phone: Part Time Part Time Spouse's name: Spouse's work phone: Social Security # PartIENT'S/RESPONSIBLE PARTY INFORMATION Responsible party: Date of Birth: Relationship to Patient: Self Spouse Other Social Security # Address: Apt. # City: State: Zip: Employer's name: Phone number: State: Zip: Zip: Zip:	Cell # () Home # (Work # ()	Soc	ial Security	/ #			
Spouse's work phone: (Date of Birth:/	Driver's License (Stat	te)	_ (Number)						
Home phone: (Employer / Name of School:					🛚 Full Ti	me	□ F	Part Tir	ne
Responsible party:	Spouse's name:		Spouse's w	ork phone: ()_					
Responsible party:	Home phone: ()	Work phone: (_)		Social Secu	ırity #				
Relationship to Patient: Self Spouse Other Social Security #					ъ.	CD: 4				
Responsible Party's home phone: ()										
Address:						-				
Employer's name:				-						
Address:										
Spouse's Employer's name:										
Spouse's Employer's name:					State:		_ Zıp:			
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 SECONDARY insurance company's name: Insurance address: City: State: Zip: SECONDARY insurance company's name: Insurance address: City: State: Zip: SECONDARY insurance company's name: Insurance address: City: State: Zip: Second Insurance address: City: State: Zip: Second Insurance ID number: Relationship to insured Second Insurance ID number: Second ID number: Seco				nouse's Wo	rk phone: ()				
PATIENT'S INSURANCE INFORMATION PRIMARY insurance company's name: Insurance address: City: State: Zip: Name of insured: Date of Birth: Relationship to insured Other				_	_					
PRIMARY insurance company's name: Insurance address: City: State: Zip: Name of insured: Date of Birth: Relationship to insured Other 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 Other Other Other Name of insured: Date of Birth: Relationship to insured Other Other Other Insurance ID number: Group number: EMERGENCY CONTACT Name of person not living with you Relationship: State: Zip: Home phone: Other Other Other 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 payment of insurance benefits to be made directly to Arthritis Medical Clinic, and any assisting physicians, for payment of insurance and characteristic pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary secure the payment of benefits. I hereby authorize this healthcare provider to release all information necessary secure the payment of benefits. I hereby authorize this healthcare provider to release all information necessary secure the payment of benefits. I hereby authorize this healthcare provider to release all information necessary secure the payment of benefits. I hereby authorize this healthcare provider to release all information necessary secure the payment of benefits. I hereby authorize this healthcare provider to release medical records on the above patient. I further agree that photocopy of this agreement shall be as valid as the original.		-					r·-			
Insurance address: City: State: Zip: Name of insured: Date of Birth: Relationship to insured Other Other Child Insurance ID number: SECONDARY insurance company's name: Insurance address: City: State: Zip: Name of insured: Date of Birth: Relationship to insured Other										
Name of insured:							 _ Zip:			
Insurance ID number:										
SECONDARY insurance company's name: Insurance address: City: State: Zip: Name of insured: Date of Birth: Relationship to insured Other Child Insurance ID number: EMERGENCY CONTACT Name of person not living with you Relationship: Address: City: State: Zip: Home phone: Work phone: 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 agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary secure the payment of benefits. I hereby authorize this healthcare provider to release medical records on the above patient. I further agree that photocopy of this agreement shall be as valid as the original.					•			☐ Ch	ild	
Insurance address: Date of Birth: Relationship to insured Self Spouse Other Child Child Self Self Spouse Self										
Name of insured:										
Insurance ID number: Group number: Group number: Child Insurance ID number: Group number:										
Name of person not living with you	Name of insured:			Kel	ationship to			-		
Name of person not living with you	Insurance ID number:	Gr	oup number	r:						
Address:	EMERGENCY CONTACT									
Home phone: () Work 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 agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary secure the payment of benefits. I hereby authorize this healthcare provider to release medical records on the above patient. I further agree that photocopy of this agreement shall be as valid as the original.										
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, f 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 agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary secure the payment of benefits. I hereby authorize this healthcare provider to release medical records on the above patient. I further agree that photocopy of this agreement shall be as valid as the original.										
I hereby give lifetime authorization for payment of insurance benefits to be made directly to Arthritis Medical Clinic, and any assisting physicians, f 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 agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary secure the payment of benefits. I hereby authorize this healthcare provider to release medical records on the above patient. I further agree that photocopy of this agreement shall be as valid as the original.	Home phone: ()		Wo	ork phone: (_)					
Date Your Signature	I hereby give lifetime authorization for payment services rendered. I understand that I am finant agree to pay all costs of collection and reasons secure the payment of benefits. I hereby authorize photocopy of this agreement shall be as valid as	t of insurance benefits to cially responsible for all of able attorney's fees. I had notize this healthcare pro- the original.	o be made d charges whet ereby author ovider to rele	irectly to Arthr her or not the ze this health ase medical r	ritis Medical y are covered care provide ecords on th	Clinic, and a d by insuran r to release re above pa	any ass ce. In all info tient.	the eve rmation I further	nt of de	efault, sary to