Date _____
Account# _____
Referring Doctor _____

Arthritis Medical Clinic

(951) 781-7700 FAX (951) 781-0313
www.ArthitisMedicalClinic.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 _____