RISER Medical Associates

PATIENT INFORMATION

FIRST NAME:_____ INITIAL:____LAST NAME:_____

ADDRESS:_____CITY_____STATE_____ ZIP_____

SEX:_____ BIRTH DATE:_____ SS#_____ MARITAL STATUS:_____

HOME PHONE #:_____ CELL PHONE #:_____

WORK PHONE #:_____ E-MAIL:_____

EMPLOYER NAME:_____ OCCUPATION:_____

EMERGENCY CONTACT NAME:_____ RELATIONSHIP:_____

EMERGENCY CONTACT PHONE #:_____

PREFERRED PHARMACY:_____

IF A MINOR WE NEED A GUARDIANS FIRST NAME, LAST NAME, DATE OF BIRTH & PHONE #:_____

I HEREBY AUTHORIZE YOU TO DISCUSS MY CHILD'S MEDICAL CONDITION WITH: _____ **THIS INCLUDES BRINGING THE CHILD IN FOR APPOINTMENTS.**

PRIMARY INSURANCE COMPANY:_____

INSURANCE ID: _____ INSURANCE GROUP #_____

CARDHOLDER INFORMATION

FIRST AND LAST NAME:_____ PHONE #_____

ADDRESS:_____ CITY_____ STATE_____

BIRTH DATE:_____ SS#_____ EMPLOYER:_____

SECONDARY INSURANCE COMPANY:_____

INSURANCE ID: _____ INSURANCE GROUP #_____

CARDHOLDER INFORMATION

FIRST AND LAST NAME:_____ PHONE #_____

ADDRESS:_____ CITY_____ STATE_____

BIRTH DATE:_____ SS#_____ EMPLOYER:_____

- I ACKNOWLEDGE THAT I WAS OFFERED AN OPPORTUNITY TO READ OR OBTAIN A COPY OT THE PRIVACY NOTICE ____HAVE READ ____HAVE NOT READ
- I AUTHORIZE RISER MEDICAL ASSOCIATES TO RELEASE MY BILLING INFORMATION. ___YES ___NO
- I AUTHORIZE RISER MEDICAL ASSOCIATES TO REQUEST MY INSURANCE CARRIER TO PAY DIRECTLY TO THE PROVIDER. I WILL PAY ALL MEDICAL SERVICES RENDERED THAT ARE NOT COVERED BY MY INSURANCE COMPANY. ___YES ___NO
- I AUTHORIZE RISER MEDICAL ASSOCIATES TO OBTAIN MY IMMUNIZATION HISTORY FROM THE STATE DEPARTMENT OF HEALTH. ___ YES ___NO
- I AUTHORIZE RISER MEDICAL ASSOCIATES TO OBTAIN MY MEDICATION HISTORY FROM MY INSURANCE AND PHARMACY. ___ YES ___ NO
- I AUTHORIZE THE TREATMENT OF THE ABOVE NAMED PERSON. ___YES ___NO

_____ _____

PATIENT / GUARDIAN SIGNATURE DATE