

- NEW PATIENT
 UPDATE

PATIENT ACCOUNT NO. _____

RIVERSIDE MEDICAL, S.C.
 Internal Medicine, Gastroenterology, Physical Therapy

- Y. Berkowicz, M.D.
 D. Goldstein, M.D.
 M. Mangurten, M.D.
 J. Pride, M.D.
 E. Yegelwel, M.D.
 D. Flershem, M.D.
 K. Nance, M.D.

Welcome To Our Office

PLEASE PRINT CLEARLY

Patient Name		First	Middle	Last	Date of Birth		Age
Home Address			Apt. No.	City	State	Zip Code	Home Phone
Occupation		Social Security No.		Marital Status		Sex	Cell Phone
				___ S ___ M ___ D ___ W			
Employer			Address				Work Phone
Name of Financial Responsible Party (FRP)			FRP Employer			FRP Work Phone	
FRP Address							
Person To Contact In Case of Emergency				Relationship	Home Phone		Work Phone or Cell Phone

INSURANCE INFORMATION: Please complete all information

PRIMARY INSURANCE	INSURANCE COMPANY NAME	ID OR POLICY NUMBER	GROUP/CODE
	INSURANCE COMPANY ADDRESS	SUBSCRIBER'S SOCIAL SECURITY NO.	DATE EFFECTIVE
	SUBSCRIBER'S NAME	HOME PHONE	RELATIONSHIP TO PATIENT
	SUBSCRIBER'S ADDRESS	WORK PHONE	SUBSCRIBER'S DATE OF BIRTH
	SUBSCRIBER'S EMPLOYER	EMPLOYER'S ADDRESS	ZIP
SECONDARY INSURANCE	INSURANCE COMPANY NAME	ID OR POLICY NUMBER	GROUP/CODE
	INSURANCE COMPANY ADDRESS	SUBSCRIBER'S SOCIAL SECURITY NO.	DATE EFFECTIVE
	SUBSCRIBER'S NAME	HOME PHONE	RELATIONSHIP TO PATIENT
	SUBSCRIBER'S ADDRESS	WORK PHONE	SUBSCRIBER'S DATE OF BIRTH
	SUBSCRIBER'S EMPLOYER	EMPLOYER'S ADDRESS	ZIP

Who referred you to this office? _____

Is your condition due to an auto accident? Yes _____ No _____

Is your injury work related? Yes _____ No _____

If yes, have you filed a claim with the Work Comp or Auto Claims Carrier? Yes _____ No _____

In today's complicated insurance environment it is essential that you familiarize yourself with your insurance benefits. Coverage and managed care networking can be complicated. DON'T WAIT FOR AN EMERGENCY. Read your plan's certificate of coverage now. You are financially responsible for services which are not covered under your insurance.

I hereby authorize Riverside Medical, S.C., to provide any insurance company information which is requested regarding treatment of myself or my dependents. I further authorize payment of medical benefits to Riverside Medical, S.C., for services rendered. I understand that I am ultimately responsible for all charges incurred and should my account go unpaid I will be responsible for any and all collection costs associated with collection of my balance. I acknowledge there will be a copy fee for any medical records. I acknowledge this authorization remains valid until revoked by me in writing.

PATIENT/GUARANTOR SIGNATURE _____

DATE _____