Riverside MEDICAL GROUP
Your family's complete medical home.

New Patient Registration Form

Last Name: ___________________________ First Name: _________________________ Middle Initial: _______

Date of Birth: _____________________________ Gender: ☐ Male ☐ Female

Address: ____________________________________ City: _______________ State: _______ Zip: __________

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American/Black

☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian

Ethnicity: ☐ Central/South America ☐ Cuban ☐ Mexican ☐ Puerto Rican

☐ Other Hispanic/Latino ☐ Non-Hispanic/Latino

Mother's Name: ____ Date of Birth: ________________________

Address: ____________________________________ City: _______________ State: _______ Zip: __________

Cell #:________________________Home #: _________________ Email: __________________________________

Employer: ____________________________ Position: _____________________ Work #: ___________________

Father's Name: ____ Date of Birth: ________________________

Address: ____________________________________ City: _______________ State: _______ Zip: __________

Cell #:________________________Home #: _________________ Email: __________________________________

Employer: ____________________________ Position: _____________________ Work #: ___________________

Legal Guardian: ____ Date of Birth: ________________________

Address: ____________________________________ City: _______________ State: _______ Zip: __________

Cell #:________________________Home #: _________________ Email: __________________________________

Employer: ____________________________ Position: _____________________ Work #: ___________________

Referring Provider: _____________________________________ Phone Number: __________________________

Pharmacy: ______________________________________ Phone Number: _______________________________

If you expect someone other than a parent to accompany your child (i.e. a grandparent, aunt, uncle, etc.) to his/her appointment, please provide their full name and date of birth below. They will need to bring a valid form of identification to the visit.

1 _____________________________ 2 ____________________________ 3 _______________________

If someone other than the person(s) listed above accompanies your child on his/her visit to Riverside, please be sure to provide us with express written permission permitting them to accompany your child to his/her visit and to have access to your child's confidential medical information.

Parent/Legal Guardian Signature: _____________________________________ Date: ___________________

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Primary Insurance

Name of Policy Holder/Guarantor: ________________________________ DOB: ___________

Relationship to Patient: ____

Policy Holder/Guarantor's Address: ____

Employment: ☐ Employed ☐ Medical Disability ☐ Self-Employed ☐ Retired ☐ Unemployed

Employer: ________________________________ Employer Address: __________________________

Insurance Company: ____

Insurance Policy ID #: ______________________________ Group #: ______________________________

Insurance Claim Address: ________________________________ Phone #: ______________________

Secondary Insurance

Name of Policy Holder/Guarantor: ________________________________ DOB: ___________

Relationship to Patient: ____

Policy Holder/Guarantor's Address: ____

Employment: ☐ Employed ☐ Medical Disability ☐ Self-Employed ☐ Retired ☐ Unemployed

Employer: ________________________________ Employer Address: __________________________

Insurance Company: ____

Insurance Policy ID #: ______________________________ Group #: ______________________________

Insurance Claim Address: ________________________________ Phone #: ______________________