

**RIVERSIDE ENDOSCOPY CENTER
PATIENT REGISTRATION INFORMATION**

ACCOUNT NUMBER

REFERRING PHYSICIAN:	TELEPHONE:
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PRIMARY PHYSICIAN:	TELEPHONE:
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PATIENT NAME: first initial last	BIRTHDATE:	AGE:	SEX:
Mr. Miss. Dr.			
Ms. Mr.			

ADDRESS:	STREET	APT#	CITY:	STATE:	ZIP CODE:
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HOME TELEPHONE:	SOCIAL SECURITY NUMBER:
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PATIENT'S EMPLOYER:	DEPARTMENT/OCCUPATION:	TELEPHONE(include extension)
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SPOUSE/GUARDIAN NAME:	EMPLOYER:	TELEPHONE(include extension)
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EMERGENCY CONTACT: (outside of the home) name-telephone-relationship
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PRIMARY INSURANCE:

IDENTIFICATION/POLICY NUMBER:	GROUP NUMBER:	PLAN NUMBER:
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POLICY HOLDER NAME:	BIRTHDATE:	SOCIAL SECURITY NUMBER:
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SECONDARY INSURANCE:

IDENTIFICATION/POLICY NUMBER:	GROUP NUMBER:	PLAN NUMBER:
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POLICY HOLDER NAME:	BIRTHDATE:	SOCIAL SECURITY NUMBER:
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I hereby authorize RIVERSIDE ENDOSCOPY CENTER to furnish information concerning my illness and treatments to INSURANCE CARRIERS, PHYSICIANS directly in my care, and for purposes of quality review and medical research studies. I authorize payment of any medical benefits to RIVERSIDE ENDOSCOPY CENTER. I certify that the above information is correct and that I am responsible for payment of services rendered. I permit a copy of this authorization to be used in place of the original.

DATE: _____ SIGNATURE: X _____

CONSENT FOR OFFICE TREATMENT: I do hereby voluntarily consent to diagnostic procedures and medical treatment by members of RIVERSIDE ENDOSCOPY CENTER as necessary in my physician's professional judgment. I am aware that the practice of medicine is not an exact science and acknowledge no guarantees can be made about the result of such treatment.

DATE: _____ SIGNATURE: X _____

MEDICARE AUTHORIZATION: I request that payment of authorized medical benefits be made on my behalf to RIVERSIDE ENDOSCOPY CENTER for services furnished me by this clinic/physician/supplier. I authorize any holder of hospital or medical information about me to be released to the HEALTH CARE FINANCING ADMINISTRATION and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

DATE: _____ SIGNATURE: X _____