RIVERVIEW MEDICAL ASSOCIATES, P.A.

4 Hartford Drive, Suite #1

Tinton Falls, NJ 07701

PLEASE PRINT AND COMPLETE ALL INFORMATION: Today's Date_____

LIVING WILL: YES_____ NO_____ Referred By_____

PATIENT_____ Home Phone _____

LAST FIRST MI

Cell Phone_____ Email_____ Work Phone_____

Street Address_____ Date of Birth_____

City_____ State_____ Social Security #_____

Zip_____ Sex: ( ) Male ( ) Female

MARITAL STATUS: Married ( ) Single ( ) Widowed ( ) Divorced ( ) Student ( ) VETERAN: Yes ( ) No ( )

Emergency Contact and Phone #_____ Relationship_____

Please write the number that best describes your ethnic background here_____.

This is required by the federal government as we transition to our Electronic Medical record.

1) African American 2) Alaskan Native 3)Asian 4) Caucasian 5) Hispanic 6) native American 7) Native Hawaiian 8) Pacific Islander 9) OTHER 10) Decline to provide this information

***RMA may___may not___ electronically view all prescriptions issued to me by all providers.

✓ PATIENT SIGNATURE: X_____ DATE_____

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Riverview Medical Associates, PA for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

✓ Date_____ Signed: X_____

NAME PARENT/GUARDIAN IF CHILD UNDER 18 YRS OLD

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be on my behalf to Riverview Medical Associates, PA for any services furnished me by the physician. I authorize any hold of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

✓ Date_____ Signed : X_____

PHOTOCOPY AS VALID AS ORIGINAL

RELEASE OF MEDICAL INFORMATION, PRIVACY PRACTICES ACKNOWLEDGEMENT – ACKNOWLEDGEMENT FORM:

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICE AND I HAVE BEEN PROVIDED THE OPPORTUNITY TO REVIEW IT. I HAVE AUTHORIZED MY MEDICAL INFORMATION TO BE RELEASED TO:

X_____ X_____ X_____

NAME RELATIONSHIP TELEPHONE #

X_____ X_____ X_____

NAME RELATIONSHIP TELEPHONE #

X_____ X_____ X_____

NAME RELATIONSHIP TELEPHONE #

THESE ARE THE PHONE #'S WHERE YOU CAN CONTACT ME.

1)_____ 2)_____ 3)_____

✓ ***SIGNATURE: X_____ DATE_____***

FOR OFFICE USE ONLY: ASSIGN CLINICAL TEAM _____(Initial)