CLINIC PATIENT INFORMATION RECORD

RIVER CITIES INTERVENTIONAL PAIN SPECIALISTS

PATIENT DEMOGRAPHICS

First:_____ **MI:**____ **Last:**_____ **DOB:** _____ **SSN:**_____

Who referred you: _____ **Primary Care Provider:**_____

Employment Status: ☐Full Time ☐Part Time ☐Unemployed ☐Disability ☐Retired ☐Student

Employer:_____

Gender: ☐ Male ☐ Female **Marital Status:** ☐S ☐M ☐W ☐D ☐Sep

Ethnicity: ☐Hispanic or Latino
☐Not Hispanic or Latino

Race:_____

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

Communication Needs:_____

Residence Address:_____
_____

Mailing Address:_____
☐*Check if the same*

Home Phone:_____
Work Phone:_____
Cell Phone:_____

Okay to receive appointment/medication reminders via text?
☐ Yes ☐ No

Email:_____ **Required to access Patient Portal*

EMERGENCY CONTACT (other than someone living with you)

First:_____ **MI:**____ **Last:**_____ **Relationship:**_____

Home Phone:_____ **Alternate Phone:**_____

Address:_____

RESPONSIBLE PARTY (Do you carry the insurance or someone else? If someone else, fill out information below)

Name:_____ **Relationship:**_____

Date of Birth:_____ **SSN:**_____

Address:_____

Home Phone:_____ **Alternative Phone:**_____

Employer:_____ **Work Phone:**_____

INSURANCE COVERAGE Is your illness/injury due to an Auto/Work Accident? ☐ Yes ☐ No

Primary Insurance Company:_____

Policy Number:_____ **Group Number:**_____

Employer:_____ **Guarantor:**_____

Secondary Insurance Company:_____

Policy Number:_____ **Group Number:**_____

Employer:_____ **Guarantor:**_____

Tertiary Insurance Company:_____

Policy Number:_____ **Group Number:**_____

Policy Number:_____ **Guarantor:**_____

ALTERNATIVE CONTACTS

We at River Cities Interventional Pain Specialists take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff members to speak only with an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below: (***Please Initial)***

_____ I **do not authorize** anyone to receive information regarding my medical care.

_____ I **authorize** my physician and the employees of River Cities Interventional Pain Specialists to speak with:

Name:_____ Relationship:_____ Phone Number:_____
☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

Name:_____ Relationship:_____ Phone Number:_____
☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

Name:_____ Relationship:_____ Phone Number:_____
☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

Alternate means of contacting me are:

Voicemail/Machine	_____ ☐*preferred*
Cell Phone	_____ ☐*preferred*
Email	_____ ☐*preferred*
Other	_____ ☐*preferred*

By signing below I understand:
-This authorization will remain in effect unless changed by me while I am a patient at this practice.

-It is my responsibility to notify this office of changes and to complete a new form.

-Any problems and/or questions concerning this form are to be referred to the Privacy Officer.

-That should I desire to revoke this authorization, I will give written notice.

_____ _____
Patient Name Date of Birth

_____
Signature Today's Date