RIVERSTONE INTEGRATIVE MEDICINE
REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	

Is this your legal name?	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

How did you hear about our clinic?

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Occupation:	Employer:	Employer address:	Employer phone no.:

Name of primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance not paid by my insurance. I also authorize Riverstone Integrative Medicine or insurance company to release any information required to

process my claims.

Patient/Guardian signature

Date