RIVERSIDE RADIOLOGY AND INTERVENTIONAL ASSOCIATES

Name: ____ **Birthdate:** ___________________

Preferred Contact Method: *Home:* ___________________ *Work:* ____________________ *Cell:* ____________________

Email Address: ____

Marital Status: *Single* *Married* *Divorced* *Widowed* *Separated* *Other*

Race: *Asian* *Black or African American* *Caucasian* *Chinese* *Filipino* *Hispanic* *Japanese* *Native American* *Native Hawaiian* *Pacific Islander* *Other:* ________________________ *Do not wish to answer:* ______________

Ethnicity: Hispanic, Non Hispanic, Other *Do not wish to answer:* ______________

Preferred Language: ____

REFERRING PHYSICIAN/GROUP NAME (full name, address, phone#):

____

____

PRIMARY CARE PHYSICIAN & OTHER PHYSICIAN/S FOLLOWING CARE (full name, address, phone #):

____

____

PHARMACY (NAME/PHONE/CITY):

____

ALLERGIES (List drug and reactions): ***Please list any changes from your last office visit***

MEDICATIONS (Include any over-the-counter medications, herbs or supplements): ***Please list any changes from your last office visit***

Name	Dose (mg)	# times per day	Reason

PLEASE SHOW YOUR INSURANCE CARD & PHOTO ID TO THE RECEPTIONIST FOR VERIFICATION

NEWS:

We are pleased to introduce our **Patient Portal**. With the Portal, you can request test results, appointments, or even a medication refill. Additionally, bill payment can be made as well as sending a message to our office. The portal will help us correspond securely, keep your information up to date, and is available from the comfort of your home. If interested, ask for a Personal Identification Number (PIN) to register before you leave today. We are excited about our Patient Portal and hope you will register and utilize its quick and easy functions.

Patient worksheet. Not permanent part of chart.