RIVERSIDE HEALTHCARE

Riverside Cancer Institute Registration Form

Last Name: _____ First Name: _____ MI: _____

SSN: _____ DOB: _____ Race: _____ Gender: M____ F____

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

Address: _____

City: _____ State _____ Zip Code _____ County ____

Daytime Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact / relationship: _____/_____

Contact Phone Number: _____

Patient - Employment Status:

Full-time / Part-time / Unemployed / Disabled / Retired (**Check one**)

Employer(s): _____

Primary Employer Address: _____

Occupation(s) _____

Employer Phone Number: _____

If Retired, Date of Retirement _____ If Disabled, Date of Disability _____

If insurance carrier is Spouse or Other – please complete:

Insured Name: _____

Insured SSN: _____ Date of Birth: _____

Full-time / Part-time / Unemployed / Disabled / Retired (**Check one**)

Occupation(s) _____

Employer(s): _____

Employer Address: _____

Employer Phone Number: _____

If Retired, Date of Retirement _____ If Disabled, Date of Disability _____

Do you have Group Health Coverage based on your/spouse current employment? Yes ☐ No ☐

Primary Insurance: _____

Secondary Insurance: _____

Please provide your insurance card(s), prescription card, and a photo ID to the receptionist.

Advanced Directives (Living Will or Power of Attorney for Health Care):
[Please provide a copy]

1. Do you have a Living Will? Yes ☐ No ☐

2. Do you have a Power of Attorney for Health Care (*legal document* allowing someone to make your healthcare decisions if you are unable to do so)? Yes ☐ No ☐

Information on Living Will and Power of Attorney for Health Care is available in the waiting room of the clinic or by asking a staff member.

Patient Needs Assessment

Do you need any teaching materials on your diagnosis?	Yes ○	No ○
Do you have any spiritual concerns and need to speak with Pastoral Care?	Yes ○	No ○
Do you have any financial needs related to your care or your ability to receive treatment or drugs that may be prescribed?	Yes ○	No ○
Do you need to speak with a social worker?	Yes ○	No ○
Do you need any medical supplies or assistive devices, such as a wheelchair, walker, etc	Yes ○	No ○

Thank you for choosing Riverside Cancer Institute for your care. Before we can share information about you with others, we will need your permission.

If there is a specific person(s) that you wish us to speak with if you are not available, please write their names below:

Name: _____ Relationship / Phone _____/_____
Name: _____ Relationship / Phone _____/_____
Name: _____ Relationship / Phone _____/_____

May we leave a message on an answering machine or with another person at your home regarding your medical records or results? Yes ☐ No ☐

Signature of patient: _____ Date: _____