Riverside Radiology & Interventional Associates
Patient Registration

Date: ___________________________

Name: (Last)_____________________________ **(First)**_____________________________ **(Middle)**___________

Address: ____

City: _________________________________ **State:** ______ **Zip:** ______________ **DOB**: __________________

Home: ___________________ **Cell:** _______________**Work:** ________________**Language:**_______________

SSN: __________________________ **Sex:** MALE/FEMALE **Email:** _____________________________________

Preferred Contact: HOME/CELL/TEXT/EMAIL **Communication Consent: Can we Text you Appt Time? Yes/No**

Can we Text you info? Yes/No **Marital Status:** SINGLE MARRIED DIVORCED WIDOWED SEPARATED OTHER

Race: BLACK HISPANIC NATIVE AMERICAN ORIENTAL/ASIAN WHITE CHINESE FILIPINO NATIVE HAWAIIAN

MULTIRACIAL PACIFIC ISLANDER JAPANESE

Employment Status: FULL-TIME PART-TIME SELF-EMPLOYED RETIRED STUDENT CHILD UNEMPLOYED OTHER

Responsible Party (Party responsible for payment): SELF SPOUSE PARENT OTHER

Name: (Last) ___________________________ **(First)** _____________________________ **(Middle)** __________

Address: (If different from above):____

City: __________________________________ **State:** __________ **Zip:** ______________ **Country:** __________

***Primary Insurance:** _____________________________________**Insured Party:** SELF SPOUSE PARENT

***Secondary Insurance:** __________________________________**Insured Party:** SELF SPOUSE PARENT

Emergency Contact:_______________________________ **Relationship:** ______________________________

Phone: ____

Family Physician & Address: ____

____

____

Ph: ______________________________________

Pharmacy Name/Phone #: ____

Riverside Office
3525 Olentangy River Road
Suite 5360
Columbus, OH 43214

Lewis Center Office
7651 Stagers Loop
Delaware, OH 43015