

Welcome

Patient Information

Please print clearly _____ Date _____

Patient Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Cell _____

Email _____

D.O.B. _____ Gender _____

DL # _____ Soc Sec # _____

*Occupation _____

*Employer _____

*Employer Address _____

*Work Phone _____

*If patient is a minor, please use parent's information.

Referring Doctor

Referring Dr. _____

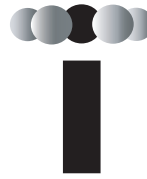
Phone _____

Allergies/Emergency Contact

List known allergies _____

In Emergency, Contact _____

Relationship _____ Phone _____



**TOWER IMAGING
VALENCIA**

Imaging by Specialists

Insurance

Insurance _____

Policy # _____ Group # _____

Secondary Insurance _____

Policy # _____ Group # _____

Guarantor _____

Relationship to patient _____

D.O.B. _____ Soc Sec # _____

Insured's Employer _____

Insured's Address _____

Work Phone _____

I hereby authorize and direct my insurance carrier to pay directly to Tower Imaging Valencia for medical services and benefits due to me under my insurance plan. I agree to pay the balance of expenses not paid under this plan. I also hereby authorize the provider to release any medical information necessary to my insurance company to process this claim. IF I AM UNINSURED, I understand I am fully responsible for all charges. I certify that the information given by me in applying for payment is correct to the best of my knowledge. I will not hold Tower Imaging Valencia responsible for any errors or omission I may have made in the completion of this form.

Signature _____

Date _____

Privacy Act Agreement

I have read and understand the Notice of Privacy Practices provided by Tower Imaging Valencia.

I hereby give permission for the following individuals to obtain medical records and information regarding my condition.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____