TOWER IMAGING
MEDICAL · GROUP
Imaging by Specialists

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REGISTRATION FORM

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 _____

* Work Phone: _____

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

Referring Doctor

Referring Doctor: _____

Phone: _____

Allergies/Emergency Contact

List known allergies: _____

_____

In Emergency, Contact: _____

Relationship: _____Phone: _____

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

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____