



# TOWER IMAGING VALENCIA

Imaging by Specialists

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## 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



### 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 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: \_\_\_\_\_

### Referring Doctor

Referring Doctor: \_\_\_\_\_

Phone: \_\_\_\_\_

### Allergies/Emergency Contact

List known allergies: \_\_\_\_\_

In Emergency, Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### 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: \_\_\_\_\_