**PATIENT INFORMATION**

Last Name: ______________________First Name:______________________
SS#:_______________________
AKA: _____________________
(Maiden name; Nickname)
Date of Birth: ____/____/____ Sex: M / F (Circle one) Married/Single/Divorced/Widow
Address: _______________________________________________City:_________________
State:_______
Zip: _____ Home: (_____) ______-_______ Work: (____) _____-_____
Cell: (____) ____-______

**PARENT OR LEGAL GUARDIAN (RESPONSIBLE PARTY INFORMATION)**
Last Name: ______________________ First Name: ________________________
SSN#:___________________
Date of Birth: ____/____/____ Sex: M / F (Circle one) Married/Single/Divorced/Widow
Address: _____________________________________ City: _________ State: ______
Zip: _______
Home: (_____) _____-_____ Work: (____) _____-_____ Cell: (____) ____-
Relationship_________

**INSURANCE INFORMATION**

**Primary Insurance Company Name: ___________________________________**
Policy Holder Name: ___________________________________________
DOB: _____/_____/_____
SSN#:______________________ Relationship to Patient: ____________________
Home: (____) ____-______
Address: _____________________________________ City: ___________________
State: ______Zip: _______

**Secondary Insurance Company Name:**

Policy Holder Name: ___________________________________________
DOB: _____/_____/_____
SSN#:_________________________ Relationship to Patient: _____________________
Address: _____________________________________ City: ___________________
State: ______Zip: _______

**For Workers' Comp & Personal Injury Cases ONLY.**

Employer: ____________________________________________ Phone No: (____)____-_____
Address: _____________________________________ City: ___________________ State: ______
Zip: _______
Date of Injury: ___/___/___ Claim No: ______________________ What kind of accident?
Auto/Work/Other
INSURANCE:___________________________________________

**Emergency Contact (Nearest Relative or Friend not living in your household)**
**I, the undersigned, hereby acknowledge that I will be responsible for paying for the services provided to me today by Southern California Diagnostic Imaging, Inc. should my**

**insurance company refuse to pay for reasons relating to my lack of a referral and/or authorization. I will also be responsible for any and all co-pays, co-insurance, and deductibles. I therefore, waive my right not to be billed pursuant to my insurance company contract. If I fail to make payment on any balance due, I (we) agree to pay all cost of collections including reasonable attorney fees and court cost should I (we) fail to pay the amount owed when due. Your signature on this form acknowledges that you agree to bear full financial responsibility for all services provided as listed below IF:**
**1. The services are not covered under your Insurance carriers benefit plan; or**
**2. The services have not been otherwise approved for payment by your insurance carrier.**

**Signature: _______________________________________ Date: ________________**

**I authorize Southern California Diagnostic Imaging Inc., to release any medical information necessary to process a claim and request assignment of benefits on my behalf.**

**Signature: _______________________________________ Date: ________________**
Name: _____________________________________
Relation to patient:___________________________
Home Phone: (____) _____-______ Alt Phone: (____) _____-_______