Valley Radiology CONSULTANTS

I. PATIENT INFORMATION

DATE: _____

PATIENT: _____

Last Name | First Name | Middle Initial

Patient Status: **Please check:** ☐ Single ☐ Married ☐ Widowed | ☐ Employed ☐ Retired | ☐ Student ☐ Part Time ☐ Full Time

MAILNG ADDRESS: [_____

Address

City | State | Zip Code | Email Address (for billing purposes)

Sex | Date of Birth | Social Security Number

PHONE: _____

Home Phone | Cell Phone | Emergency Phone | Work Phone

If patient is a minor:

Responsible party: Last Name | First Name | Middle Name

REFERRING PHYSICIAN: _____

II. INSURANCE

PRIMARY INSURANCE _____

(Insurance, Medicare, Medi-Cal)

Insured: _____

(Name and relationship if different from patient) | (Birth date) | (Soc. Sec. #)

ID/Subscriber #: _____ GROUP # or Name: _____

(Insurance, Medicare, Medi-Cal) | (if applicable)

SECOND INSURANCE _____

(Insurance, Medicare, Medi-Cal)

Insured: _____

(Name and relationship if different from patient) | (Birth date) | (Soc. Sec. #)

ID/Subscriber #: _____ GROUP # or Name: _____

III. IS THIS AN INJURY OR ILLNESS DUE TO AN ACCIDENT? ☐ No ☐ Yes

If yes, Injury Date: _____ **Please Check:** ☐ **Auto** ☐ **Job Related** ☐ **Other** _____

If this is a job related injury or illness, please complete: **(explain)**

Employer: _____ WC Claim#: _____

Workers Compensation Insurance: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Is there a litigation pending regarding the injury, please complete:

Attorney: Phone: