San Gabriel Valley Diagnostic Center

Registration Form

PATIENT DETAILS

Patient ID#			**SSN#**		
Full Name (Last Name, First Name):					
Date of Birth:		**Gender:**		**Marital Status:**	☐ M ☐ S ☐ D
Preferred Language:			Employer:		
Ethnicity:		**Race:**		**Smoker:**	☐ Yes ☐ No How Long?

CONTACT INFORMATION

Address:		**City, State & Zip:**	
Phone (Home):		Phone (Business):	
Email:		**Phone (Cell):**	
Emergency Contact:		Phone#:	
Emergency Contact Relationship:			

GUARANTOR

FINANCIALLY RESPONSIBLE (IF MINOR PLEASE FILLOUT)

☐ SELF/SAME AS ABOVE

Relationship to Patient:				Are you the insured?	☐ Yes	☐ No	
First Name:		MI:		Last Name:			
Address:				City, State & Zip:			
Date of Birth:		Age:		SSN#:		Gender:	
Phone (Home):				Phone (Cell):			
Employer:				Work (Phone):			

HEALTH PLAN INFORMATION

INSURANCE *(*__REQUIRED FIELDS__*)

PLEASE COMPLETE INFORMATION BELOW & GIVE YOUR INSURANCE CARDS TO STAFF

***Insurance Carrier (PRIMARY)**							
Address:				City, State & Zip:			
Phone:				**Policy Number:**			
Group #:							
*Subscribers Name:							
*Date of Birth:		Age:		SSN#		Gender:	
*Relation to Patient:							
Insurance Carrier (SECONDARY):							
Address:				City, State & Zip:			
Phone:				Policy Number:			
Group #				Group Name:			
Subscribers Name:							
Date of Birth:		Age:		SSN:		Gender:	
Relation to Patient:							

ASSIGNMENT OF BENEFITS

I consent to treatment necessary for the care of the above named patient. I hereby authorize the release of my medical records to the referring physician, family physician and to my insurance company, if applicable. I also consent to the release of my applicable medical record information from my treating a/o referring physician, as may be requested by San Gabriel Valley Diagnostic Center (SGVDC). I acknowledge full financial responsibility for services rendered by SGVDC. I understand that payment of charges incurred is due at the time of service unless other definite arrangements have been made prior to treatment. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate. I further authorize and request that the insurance payments be made directly to SGVDC. If these benefits are not assigned to SGVDC, I agree to forward to SGVDC all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. I authorize and permit the use of a copied version of this document to be used in part as the original. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

________________________ ____

Date **Signature**