San Gabriel Valley Diagnostic Center

Registration Form For Injury Claims

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):	( )

INJURY CLAIM

INJURY CLAIM (If Today's visit is due to an injury complete information below)

Type of Injury: ☐ **Auto** ☐ **Work** ☐ **Slip/Fall** ☐ **Other** _____

Auto Injury:		Place (Place or State where injury accrued):			
Date of Injury:	/ /	Auto (Driver):	☐ Yes ☐ No	Auto (Passenger):	☐ Yes ☐ No
Insurance Carrier:		Claim #:		Policy Number:	
Insurance Carrier Address:				Phone # (Ins):	( )
Subscribers Name:				Date of Birth:	

Work Injury:					
Date of Injury:		Claim#:		Claim Adjustor:	
Employer at time of injury:				Phone#:	( )
Employer Address:				City, State & Zip:	
Representing Attorney:				Phone#:	( )
Address:				City, State & Zip:	

ASSIGNMENT AUTHORIZATION

I hereby authorize and direct my attorney to pay directly to this provider for all medical services rendered to me. I agree to pay the balance not paid under this lien agreement for services performed. I hereby authorize my attorney to release copies of my settlement information, such as the settlement draft and disbursement to these providers. I also authorize this provider to release to my attorney and insurance carrier, any medical information necessary to process this claim. If during the course of the case there is a change of attorney or if the case is dropped, I become fully responsible for all charges for this procedure(s).

I understand I am personally and fully responsible for all charges

NOTICE: Failure to provide complete information may result in the patient being held financially responsible for service(s) rendered.

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

Patient Signature: _____ **Date:** _____