

**San Gabriel Valley Diagnostic Center  
Registration Form**

**MR#** \_\_\_\_\_

*PLEASE PRINT CLEARLY*

**PATIENT**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Marital Status: **M** \_\_\_\_\_ **S** \_\_\_\_\_ **D** \_\_\_\_\_ **O** \_\_\_\_\_  
SSN: \_\_\_-\_\_\_-\_\_\_ Sex: \_\_\_\_\_ Drivers License/ID#: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone (home): ( ) \_\_\_\_\_ - \_\_\_\_\_ Phone (cell): ( ) \_\_\_\_\_ - \_\_\_\_\_  
Phone (work): ( ) \_\_\_\_\_ - \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**GUARANTOR**

**RESPONSIBLE PARTY INFORMATION (PLEASE COMPLETE IF PATIENT IS MINOR):**

Relationship to patient: \_\_\_\_\_ Are you the insured? \_\_\_ Yes \_\_\_ No  
First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_-\_\_\_-\_\_\_ Sex: \_\_\_\_\_  
Phone (home): ( ) \_\_\_\_\_ - \_\_\_\_\_ Phone (work): ( ) \_\_\_\_\_ - \_\_\_\_\_  
Employer: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**ACCOUNT/BILLING**

**INSURANCE (PLEASE PRESENT YOUR INSURANCE CARD(S) TO THE FRONT DESK):**

Insurance Carrier (**PRIMARY**): \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Policy Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_-\_\_\_-\_\_\_ Sex: \_\_\_\_\_  
Relation to patient: \_\_\_\_\_  
Insurance Carrier (**SECONDARY**): \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone (home): ( ) \_\_\_\_\_ - \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Policy Group: \_\_\_\_\_ Group Name: \_\_\_\_\_  
Subscriber First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_-\_\_\_-\_\_\_ Sex: \_\_\_\_\_  
Relation to patient: \_\_\_\_\_

**ACCIDENT ACCOUNT**

**INJURY RELATED CLAIM ("IF TODAY'S VISIT IS DUE TO AN INJURY PLEASE COMPLETE BELOW")**

What type of injury? \_\_\_\_\_ Work \_\_\_\_\_ Auto (Driver) \_\_\_\_\_ Auto (Passenger) \_\_\_\_\_ Slip/Fall \_\_\_\_\_ Other \_\_\_\_\_  
Date of Injury: \_\_\_/\_\_\_/\_\_\_ Claim #: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Insurance Carrier: \_\_\_\_\_ Phone (Ins): ( ) \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Employer at time of injury: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Representing Attorney: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

I consent to treatment necessary for the care of the above named patient. I hereby authorize the release of medical records to the referring physician, family physician and to my insurance company, if applicable. I acknowledge full financial responsibility for services rendered by SAN GABRIEL VALLEY DIAGNOSTIC CENTER. I understand that payment of charges incurred is due at the time of service unless other definite arrangements have been made prior to treatment. I agree to pay reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that the insurance payments be made directly to SAN GABRIEL VALLEY DIAGNOSTIC CENTER. 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