

Jacket# _____
(office use only)

Please Print

Patient First Name _____ Middle _____ Last _____

Home Phone _____ Work Phone _____ Cell _____

Address _____ City _____ State _____ Zip _____

Sex M F Birth Date _____ SS# _____ Marital Status: _____

Employer _____ Address _____ Phone _____

Spouse/Parent _____ SS# _____ Birth Date _____

Employer Address _____ Phone _____

Emergency Contact _____ Phone _____

PRIMARY INSURANCE

Primary Insurance _____ Effective Date _____

Cardholder Name _____ Birth Date _____ Relationship _____

Certificate/ID# _____ Group/Union# _____ Plan Type _____

SECONDARY INSURANCE

Secondary Insurance _____ Effective Date _____

Cardholder Name _____ Birth Date _____ Relationship _____

Certificate/ID# _____ Group/Union# _____ Plan Type _____

Name of Referring Physician: _____

ALLERGIES: Please List

I, THE UNDERSIGNED, AGREE TO ASSIGN, DIRECTLY TO VISALIA IMAGING AND OPEN MRI, ALL SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE VISALIA IMAGING AND OPEN MRI TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

I AGREE TO NOTIFY VISALIA IMAGING AND MRI IF ANY OF THE ABOVE INFORMATION CHANGES DURING THE COURSE OF TREATMENT.

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____