



PATIENT INFORMATION

Last Name: _____ First Name: _____ SSN#: _____
Date of Birth: ___/___/___ Sex: M / F (Circle one) Married/Single/Divorced/Widow
Address: _____ City: _____ State: _____
Zip: _____ Home: (____) _____ - _____ Work: (____) _____ - _____ Cell: (____) _____ - _____

PARENT, SPOUSE OR LEGAL GUARDIAN (RESPONSIBLE PARTY INFORMATION)

Last Name: _____ First Name: _____ SSN#: _____
Date of Birth: ___/___/___ Sex: M / F (Circle one) Married/Single/Divorced/Widow
Address: _____ City: _____ State: _____ Zip: _____
Home: (____) _____ - _____ Work: (____) _____ - _____ Cell: (____) _____ - _____ Relationship _____

INSURANCE INFORMATION

Primary Insurance Company Name: _____
Policy Holder Name: _____ DOB: ___/___/___
SSN#: _____ Relationship to Patient: _____ Home: (____) _____ - _____
Address: _____ City: _____ State: _____ Zip: _____
Secondary Insurance Company Name: _____
Policy Holder Name: _____ DOB: ___/___/___
SSN#: _____ Relationship to Patient: _____
Address: _____ City: _____ State: _____ Zip: _____

For Workers' Comp & Personal Injury Cases ONLY.

Employer: _____ Phone No: (____) _____ - _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Injury: ___/___/___ Claim No: _____ What kind of accident? Auto/Work/Other
INSURANCE: _____

Emergency Contact (Nearest Relative or Friend not living in your household)

Name: _____ Relation to patient: _____
Home Phone: (____) _____ - _____ Alt Phone: (____) _____ - _____

I authorize my insurance benefits to be paid directly to Orange County Diagnostics. ***I acknowledge that if my insurance does not approve or services are not covered under my healthcare plan*** I will be financially responsible for all charges incurred during my visit. I authorize the release of any information necessary to process an insurance claim. I permit a photocopy of this authorization to be used in place of the original.

Signature of patient/guarantor: _____ Date: ___/___/___

Relationship to patient: _____