Orange County Diagnostics

PATIENT INFORMATION FORM

Social Security #: _____-_____-_____

Last Name: _____First Name: _____Middle Name: _____

Alias: _____ DOB ___-____-_____ Gender: ☐M ☐F Marital Status: ☐M ☐S ☐D ☐Other_____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ____-_____-_____ Work: _____-_____-_____ Mobile: _____-_____-_____

If minor responsible party: _____ Date Of Birth: _____

Address: _____

Emergency Contact: _____ Phone: _____

**Please answer the following as part of federal reporting requirements:**

**Ethnicity**: ☐Hispanic or Latino ☐Non Hispanic or Latino ☐Decline **Primary Language** _____

**Race**: ☐White ☐Black ☐Asian ☐Native American or Alaskan ☐Hawaii or Pacific Islander ☐Other/Multiple ☐Decline

**Smoking Status**: ☐Every day ☐Occasional ☐ Former ☐Never ☐Decline

**Height**:___ft.__in. **Weight**:____lbs **Email**: _____

**Allergies:** ☐ No Known Allergies Type of Reaction

Medications: _____ Mild Moderate Major _____

_____ Mild Moderate Major _____

Other: _____ Mild Moderate Major _____

**Medication:** ☐ No Medications

Drug Name: _____ _____ _____ _____

Dosage: _____ _____ _____ _____

Pharmacy: _____

## Insurance Information

☐ **Same as Patient**

**Insured's Last Name**: _____ **First Name**: _____

Date of Birth: _____ SS#:_____ Relation to Patient:_____

Mailing Address: _____ City: _____ State: _____ Zip Code_____

Home Phone: _____ Cell Phone: _____

**Primary Insurance**: _____

Group Name: _____ ID # _____

**Secondary Insurance**: _____

Group Name: _____ ID # _____

Insured's Last Name: _____ First Name: _____ DOB: _____

I, the undersigned, hereby acknowledge that I will be responsible for paying for the services provided to me today by Orange County Diagnostics should my insurance company refuse to pay for reasons relating to my lack of a referral and/or authorization. I will also be responsible for any and all co-pays, co-insurance, and deductibles. I therefore, waive my right not to be billed pursuant to my insurance company contract. If I fail to make payment on any balance due, I (we) agree to pay all cost of collections including reasonable attorney fees and court cost should I (we) fail to pay the amount owed when due.

Your signature on this form acknowledges that you agree to bear full financial responsibility for all services provided as listed below IF:

1. The services are not covered under your Insurance carriers benefit plan; or
2. The services have not been otherwise approved for payment by your insurance carrier

I authorize Orange County Diagnostics to release any medical information necessary to process a claim and request assignment of benefits on my behalf.

**Signature of Patient/Guardian: _____** **Date: _____**

**Print Name of Patient/Guardian:_____**

**Relationship to Patient: _____**