PACIFIC MEDICAL
Imaging & Oncology Center

Patient Registration Form

PATIENT NAME: **DATE OF BIRTH:**

ADDRESS: **HOME PHONE:**

CITY: **STATE:** **ZIP:** **SOCIAL SECURITY #**

EMPLOYER: **WORK #**

REFERRING PHYSICIAN: **PHONE:**

EMERGENCY CONTACT:

NAME: **RELATIONSHIP:** **PHONE:**

INSURANCE INFORMATION

~~ PLEASE HAVE YOUR INSURANCE CARDS READY FOR PHOTOCOPYING ~~

PRIMARY INS: **NAME OF INSURED:**

POLICY # **GROUP #**

SECONDARY INS: **NAME OF INSURED:**

POLICY # **GROUP #**

Assignment of Insurance Benefits:
I hereby authorize payment directly to Pacific Medical Imaging & Oncology Center (PMIOC); and in the event of insurance to myself, I agree to authorize release of the Explanation of Insurance Benefits. In the event of any refusal of any insurance company or attorney to pay the bill, I agree to pay the balance. I agree to be responsible for said debt and any collection fees involved in the collection of this debt. I also understand that PMIOC bills/submits claims to my insurance for medical services rendered at the facility as a courtesy. However, in order to perform this courtesy, I the patient must provide PMIOC with all the necessary information/documentation pertaining to my insurance/medical coverage to do so.

PATIENT/GUARANTOR SIGNATURE:_____ **DATE:**

Release of Information:
This authorization or photo copy hereof, will authorize the release of full and complete medical records/reports and any other records when necessary to governmental agencies, insurance carriers, and review agencies for payers responsible for pre-certification and payment services rendered. I also authorize the center to permit such payers and their review agencies to examine and make copies of my records as requested for payment as permitted by Federal and State law. I further authorize release of previous medical records as requested by the center.

PATIENT/GUARANTOR SIGNATURE:_____ **DATE:**

Authorization for Release of Medical Information:

I hereby authorize the release of my records from:

_____ to
(Facility Name/Address)

Pacific Medical Imaging & Oncology Center (PMIOC) at 707 S. Garfield Ave. Suite B-001, Alhambra, CA 91801.

PATIENT/GUARANTOR SIGNATURE:_____ **DATE:**