CASTRO VALLEY
OPEN MRI

Date _____

PATIENT INFORMATION

Primary Phone _____ (home/cell) Secondary Phone _____ (home/cell) Work Phone: _____

Name _____ SSN _____
Last First Middle

Street Address _____

City _____ State _____ Zip_____

Sex ☐Male ☐Female Age _____ Birth Date _____ Marital Status ☐M ☐S ☐D ☐W

Patient Employer/School _____ Occupation_____ _____

Employer Address _____ Business Phone No. _____

Primary Care Physician _____ Have you obtained a referral from your PCP for this visit? _____

Where did injury occur? ☐At work ☐At school ☐Car accident ☐Other _____

In case of emergency who should be notified _____ Relationship _____ Phone No. _____

INSURANCE INFORMATION

Person responsible for account _____ Birthdate _____

Relationship to patient_____Phone No._____ SSN_____

Address (if different than above) _____

City _____ State _____ Zip _____

Responsible party employed by _____ Occupation _____

Employer address _____ Business Phone No. _____

Insurance Company _____

ID No. _____ Group No. _____

Cardholder's Name _____ Relationship _____ Cardholders' DOB _____

Insurance Company Address _____ Phone No. _____

SECONDARY/SCHOOL INSURANCE

Insurance Company _____

ID No. _____ Group No. _____

Cardholder's Name _____ Relationship _____ Cardholders' DOB _____

Insurance Company Address _____ Phone No. _____

ASSIGNMENT AND RELEASE

I hereby authorize any insurance benefits to be paid directly to the business office of CV Open MRI. I hereby authorize the release of all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges incurred whether or not paid by an insurance company. I understand that I am financially responsible for the charges not covered by my insurance. I hereby authorize CV Open MRI to release any information required in the course of my examination or treatment. This agreement will remain in effect until revoked by me in writing.

Signature of Patient _____ Date _____
(Parent or Guardian if under 18)