PATIENT INFORMATION

First _____ **Middle** _____ **Last**_____ **Birth Date:** _____/_____/_____

Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone#: (_____) _____ **Cell#:** (_____) _____ **Please Circle:** Male or Female

Social Security#: _____ **Marital Status:** Single/ Married / Divorced / Widowed or Widower / Other

Employer: _____ **Employer Phone#:** (_____) _____

GUARANTOR INFORMATION

Relationship to the Guarantor: (i.e. Self, Spouse, Child, etc) _____

First _____ **Middle** _____ **Last** _____

Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip Code + 4 digits:** _____ (_____)

Home Phone#: (____) _____ **Cell#:** (____) _____

Birth Date: _____/_____/_____ **Social Security#:** _____ **Male or Female**
(Required)

EMERGENCY CONTACT

(Relative or friend *NOT* living with you)

Name: _____ **Phone# :(_____)** _____ **Relationship:** _____

INSURANCE INFORMATION

PRIMARY: _____

Subscriber's Name: _____ **Birth Date:** _____/_____/_____
(Required)

SECONDARY: _____

Subscriber's Name: _____ Birth Date: _____/_____/_____
(Required)

LABOR & INDUSTRIES CLAIM ***(All Required Info)***

CLAIM#: _____ **Date of Injury:** _____/_____/_____

Employer for L&I Claim: _____ **Employer Phone#: (_____)** _____

Assignment & Release: I authorize release of any information required for Tri-City Radiology claims. I acknowledge full responsibility for the payment of services rendered and agree I will take responsibility for any and all costs incurred by my failure to remit for services rendered. The above information is complete and accurate to the best of my knowledge. I acknowledge that I have been informed of my privacy rights regarding my health information. **I understand it is my responsibility to know my insurance coverage and when a prior authorization is required. I assume liability for all non-covered charges and deductibles.**

Signature: _____ **Date:** _____/_____/_____