WCRC | West Coast Radiology Centers

Capability. Convenience. Service.

Patient Information Sheet

Patient Information

Name: _____ (Last / First / M.I.) Sex: _____ Date of Birth: _____ (Mo / Day / Year) Age: _____

Address: _____ (Street Number / Apt. #) Home Phone: (_____) _____

_____ (City / State / Zip) Work Phone: (_____) _____

Email Address: _____ Cell Phone: (_____) _____

Social Security #: _____ If work related, injury date: _____

Referring Dr: _____ Phone #: _____ Employer: _____

Subscriber Information

Name: _____ (Last / First / M.I.) Home Phone: (_____) _____

Address: _____ (Street Number / Apt. #) Cell Phone: (_____) _____

_____ (City / State / Zip) Work Phone: (_____) _____

Social Security #: _____ Employer: _____

Primary Insurance / Group Name: _____

Insurance billing address: _____ (Street Number) Birth date of insured: _____

_____ (City / State / Zip) Relationship to Patient: _____

ID #: _____ Group #: _____

Secondary Information

Secondary Insurance / Group Name: _____

Name of Insured: _____ (Last / First / M.I.) SSN#: _____

Insurance billing address: _____ (Street Number) Birth date of insured: _____

_____ (City / State / Zip)

ID #: _____ Group #: _____

Authorizations

INSURANCE

I hereby authorize and direct my insurance carrier to pay directly to **West Rad Medical Group** *any benefits due me under my insurance plan. I agree that should it be determined that I am ineligible or services are denied me under my Health/Insurance Plan, I will be responsible for payment to West Rad Medical Group for those services disallowed, ineligible, or not covered.*

I authorize **West Rad Medical Group** *to release to my insurance carrier any medical information necessary to process this claim. I understand that I may be responsible for any out of pocket expenses or co-pays if one or more of the following apply:* ❑ *Point of Service* ❑ *HMO*

AUTHORIZED SIGNATURE: X _____ *Date:* _____

ACKNOWLEDGEMENTS

I understand that pre-authorization may be required for some procedures.
I acknowledge this fact and agree that I will be financially responsible should my insurance carrier deny my claim for lack of a pre-authorization.

AUTHORIZED SIGNATURE: X _____ *Date:* _____

If not patient, relationship: _____

West Coast Radiology Centers' "Notice of Privacy Practices" are posted and available upon request. **Initials:** _____