WOMEN'S IMAGING CENTER
An IMAGINGPARTNERS Facility

Women's Imaging Center
Trico Sycamore Plaza Medical Office Building
431 S. Batavia St., Suite 100
Orange, CA 92868
Phone: 714-771-8360
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IMAGINGPARTNERS
Diagnostic Medical Imaging
A partnership with Moran, Rowen & Dorsey and St. Joseph Hospital of Orange

Patient Information Sheet

Patient Name: _____ Patient ID: _____
(last) (first) (m.i.)

DOB: ____/____/_____ ☐M or ☐F Email: _____
MM DD YYYY
Note: By providing the email address, the patient agrees to receive communication via email.

Address: _____
(address) (city) (state) (zip code)

Home phone: _____ Work phone: _____ Cell phone: _____

Referring Doctor: _____ Office phone: _____ Office fax: _____
(physician name)

Responsible party: _____ Address: _____
(full name) (address) (city) (state) (zip code)

Emergency contact: _____ Relationship: _____ Phone: _____
(name)

Primary insurance: _____ ID number: _____ Group number: _____
(insurance co. name)

Subscriber name: _____ Relationship to patient: _____ Subscriber DOB: _____

Secondary insurance: _____ Plan number: _____
(insurance co. name)

Claims mailing address: _____

Subscriber name: _____ Relationship to patient: _____ Subscriber DOB: _____

Please sign below and **initial next to each statement** acknowledging that you have read, understand, and agree to the above:

_____ I authorize direct payment to be made by my insurance carrier to Moran, Rowen, & Dorsey, Inc. for any benefits due me under my insurance plan.

_____ I authorize Moran, Rowen, & Dorsey, Inc. to release to my insurance carrier any medical information necessary to process this claim. I also authorize the release of any medical records for the purpose of healthcare operations.

_____ I understand that my insurance company is being billed for services rendered and I agree that I am financially responsible to pay any charges not covered by my insurance plan as well as any deductibles and coinsurances due.

_____ I understand that pre-authorization may be required for some procedures and it is my responsibility through my referring physician to ensure pre-authorization is obtained prior to my appointment. I agree that I will be financially responsible should my insurance carrier deny my claim, for lack of pre-authorization.

Signature of patient or responsible party: _____ **Date** _____

Name of signer and relationship to patient (if other than patient): _____