Inland Empire Imaging Center

260 East Ontario Ave. Suite 101A
Corona, CA 92879
tel: 951-284-1920 fax: 951-284-1921

PET/CT PET/BONE CT ULTRASOUND

Referring Physician: _____

Patient Information

LAST NAME:	FIRST NAME:	MIDDLE INITIAL
DATE OF BIRTH:	Male Female	SS#
ADDRESS:		
CITY:	STATE:	ZIP CODE:
PREFERRED PHONE: HOME MOBILE OTHER		
HOME:	MOBILE	OTHER
EMAIL		
MARITIAL STATUS: SINGLE MARRIED OTHER		

Emergency Contact

NAME:	RELATIONSHIP TO PATIENT:
PHONE: HOME MOBILE OTHER	

Employment Information

COMPANY NAME:	TITLE/DEPARTMENT
ADDRESS:	PHONE

Primary Insurance

INSURANCE COMPANY	ID #:
EFFECTIVE DATE:	GROUP #:

Secondary Insurance

INSURANCE COMPANY:	ID #:
EFFECTIVE DATE:	GROUP 3:

AUTHORIZATION FOR TREATMENT AND ASSIGNMENT BENEFITS

I HEREBY AUTHORIZE INLAND EMPIRE IMAGING, INC. TO PERFORM SUCH DIAGNOSTICS WHICH HAVE BEN REQUESTED BY THE REFERRING PHYSICIAN AND ARE NECESSARY FOR THE WELFARE OF THE PATIENT IDENTIFIED ABOVE.

I HEREBY AUTHORIZE INLAND EMPIRE IMAGING CENTER TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING THE DIAGNOSTIC SERVICES. I HEREBY IRREVOCABLY ASSIGN ALL BENEFITS, INCLUDING MAJOR MEDICAL BENEFITS FOR MEDICAL SERVICES RENDERED TO BE PAID DIRECTLY TO THE IMAGING CENTER IN ACCORDANCE WITH CALIFORNIA INSURANCE CODE SECTION 10133. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT ULTIMATELY, I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I ALSO UNDERSTAND THAAT IT IS MY RESPONSIBILITY TO ADVISE THIS GROUP OF ANY CHANGES IN MY PERSONAL AND/OR INSURANCE INFORMATION.

PATIENT SIGNATURE DATE