TEMECULA VALLEY NUCLEAR MEDICINE, Inc.

25485 Medical Center Drive
Suite 102
Murrieta, CA 92562

Patient e-mail address

Pt. Last Name	First Name	Middle Initial	Male / Female	Marital Status

Mailing Address (IF PO BOX, physical address required)	City	State and Zip Code

Home Phone #	Cell #	Employer	Work Telephone & Est.

Work Address	City	State and Zip Code

Date of Birth	Social Security Number - **required**	Driver Lic. No.	State & Expiration Date

Referring Physician	Family Physician

Spouse's Name	Spouse's Employer

Address of Spouse's Employer	City	State, Zip and Phone Number

Name of Closest Living Relative (not residing with you)	Address	City, State & Zip	Phone #

Person to contact in case of Emergency	(Day Phone)	(Evening Phone)

PRIMARY INSURANCE INFORMATION	**SECONDARY INSURANCE INFORMATION**
Ins. Co. Name & Claims Address	2nd Ins. Co. Name & Claims Address
Name of Insured	Name of Insured
Insured's Relationship to Patient	Insured's Relationship to Patient
Group #, Name of Insured's Employer	Group #, Name of Insured's Employer
Insured's Social Security No. and Birthdate	Insured's Social Security No. and Birthdate

TEMECULA VALLEY NUCLEAR MEDICINE, Inc.

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO TEMECULA VALLEY NUCLEAR MEDICINE, Inc. FOR SERVICES FURNISHED ME. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY FOR THE PAYMENT OF MEDICAL CLAIMS TO MY INSURANCE COMPANY/PAYING ENTITY. A COPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. I HEREBY ACCEPT FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED WHETHER OR NOT I HAVE INSURANCE COVERAGE. I FULLY UNDERSTAND THAT IF ANY LEGAL FEES AND INTEREST ARE INCURRED, THAT I, THE UNDERSIGNED, WILL BE FULLY RESPONSIBLE FOR THOSE FEES. I ALSO ACKNOWLEDGE THAT IF MY BALANCE IS 30 DAYS PAST DUE, MY ACCOUNT WILL BE ASSESSED MONTHLY REBILLING FEES IN THE AMOUNT OF $15 OR MAXIMUM ALLOWED BY LAW, UNTIL THE BALANCE IS PAID IN FULL. THESE FEES WILL BE MY RESPONSIBILITY. I HEREBY CONSENT TO MEDICAL TREATMENT, TESTS AND PROCEDURES THAT MY PHYSICIAN(S) DEEMS ADVISABLE AND NECESSARY BASED ON HIS/HER JUDGEMENT.

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Signature of Patient, Parent - if patient is a minor or Legal Agent **Date Signed**

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Print name

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IF YOU ARE COVERED BY MEDICARE PLEASE COMPLETE THE MEDICARE *ASSIGNMENT OF BENEFITS BELOW;*

MEDICARE
ASSIGNMENT OF INSURANCE BENEFITS
(Please Print)

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Patient Last Name **First Name** **Middle Name**

I request that payment of authorized Medicare benefits be made on my behalf to Temecula Valley Nuclear Medicine for services furnished me by Temecula Valley Nuclear Medicine. I permit a copy of this authorization to the Health Care Financing Administration (Medicare) or its agents for any information to determine these benefits or the benefits payable related services.

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Signature of Patient or Legal Agent **Date**