



**TOWER  
SAINT JOHN'S  
IMAGING**

*Imaging by Specialists*

2202 WILSHIRE BLVD., SANTA MONICA, CA 90403 • TEL: 310-264-9000 • FAX: 310-264-9004 • WWW.TOWERSJI.COM

*Please print clearly*

First Name \_\_\_\_\_ Last Name \_\_\_\_\_  
Address \_\_\_\_\_ Apt # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Home ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Ext \_\_\_\_\_  
Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex \_\_\_\_ Drivers License # \_\_\_\_\_ Soc Sec # \_\_\_\_\_  
Employer/School \_\_\_\_\_ If student, Full-time \_\_\_\_\_ Part-time \_\_\_\_\_  
Employer Address \_\_\_\_\_

Referring Dr. \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Please list any known allergies \_\_\_\_\_  
Person to contact in case of an emergency \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone ( ) \_\_\_\_\_ Address \_\_\_\_\_

Is today's visit related to an accident or injury? Y \_\_\_\_ N \_\_\_\_ Auto Accident \_\_\_\_ Work Related \_\_\_\_ Other \_\_\_\_

**Guarantor Information (Please complete if insured person is Spouse, Partner, Parent or Guardian)**

Name of Insured \_\_\_\_\_ Insured's relationship to patient \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Phone Home ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Ext \_\_\_\_\_  
Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex \_\_\_\_ Drivers License # \_\_\_\_\_ Soc Sec # \_\_\_\_\_  
Employer \_\_\_\_\_

If you are a female, are you pregnant? Yes \_\_\_\_ No \_\_\_\_

**Insurance Information (Please present insurance cards with completed form)**

Insurance \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
**Secondary Insurance** \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT REGISTRATION**



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PATIENT REGISTRATION

ASSIGNMENT OF BENEFITS: I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due to me under my insurance plan. I agree to pay the balance of charges not paid under my plan. I also hereby authorize this provider to use and disclose any of my personal medical information for treatment and payment (including to my insurance company). Should the account be referred to an attorney for collection, the undersigned shall pay attorney's fees and other collection expenses. IF I AM UNISURED, I understand I am fully responsible for all charges.

Signature \_\_\_\_\_ Date \_\_\_\_\_

CONSENT FOR MEDICAL AND SURGICAL TREATMENT: I authorize Imaging Center to furnish the necessary medical and surgical treatment, or procedures, including diagnostic x-ray and laboratory procedures, anesthesia, drugs and supplies as may be ordered by attending physician(s), his assistants or designees. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as the result of treatment or diagnostic procedures conducted in the Imaging Center. I recognize that the physicians who practice at the Imaging Center may not be employees or agents of the Imaging Center but independent physicians. Imaging Center contracts with those independent physicians for services physicians normally provide, any questions relating to care that my physician has given ordered, should be directed to him/her.

Signature \_\_\_\_\_ Date \_\_\_\_\_

LIFETIME MEDICARE (B) SIGNATURE AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare & Medicaid Services or its intermediaries or carriers, or to the billing agent of Imaging Center any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for any deductible and coinsurance.

NOTE: MEDICARE WILL ONLY PAY FOR A ROUTINE MAMMOGRAM ONCE PER YEAR AND ONLY FOR THOSE 65 OR OLDER.

Signature \_\_\_\_\_ Date \_\_\_\_\_

IF PATIENT IS UNDER 18:

I hereby give my permission for \_\_\_\_\_ to be treated at Imaging Center.

Signature/Telephone Verification \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

PATIENT UNABLE TO SIGN DUE TO:

\_\_\_\_\_

Signature Guardian \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_