



**Orange County Vital Imaging**

1120 W. La Veta Avenue, Suite 150, Orange, CA 92868 • Phone: 714-558-2040 • Fax: 714-558-2047

[www.vitalimaging.com](http://www.vitalimaging.com)

Patient Name Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Address 1 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Male  Female  Birthdate \_\_\_\_\_

Age \_\_\_\_\_ E-mail \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Person to Contact in Emergency \_\_\_\_\_ Phone # \_\_\_\_\_

Responsible Party (if different) Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PAYMENT IS DUE AT TIME OF SERVICE**

Primary Insurance Company \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Medicare # \_\_\_\_\_

Patient's Relationship to Subscriber \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Patient's Relationship to Subscriber \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_