Thousand Oaks Radiology

PATIENT REGISTRATION INFORMATION

Patient Name _____ Today's Date _____

Date of Birth _____ Gender _____ Social Security Number _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

REFERRING PHYSICIAN: _____

RESPONSIBLE PARTY/GUARANTOR INFORMATION

Name _____ Date of Birth _____

PATIENT'S RELATIONSHIP TO GUARANTOR - (Please circle) **SELF** **SPOUSE** **CHILD** **OTHER**

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS

Patient's Signature: _____Date: _____

I hereby authorize _____to send any Report, CD and any other medical records to **THOUSAND OAKS RADIOLOGY**

Date(s) of service: _____

Exam(s) requested: _____

Type of Record Needed:
Report Only _____ CD Only _____ Report and CD _____

Medical records are to be sent/faxed to:
Thousand Oaks Radiology
2180 Lynn Rd., Thousand Oaks, CA 91360
t. (805) 495-9442 f. (805) 496-6595