Valley Radiologists
Complete Diagnostic Imaging

SDI southwest diagnostic imaging

On-Line Registration

**Required Field*

*First Name: _____ *Last Name: _____ Maiden Name: _____

Prefix: ☐ Dr. ☐ Mr. ☐ Ms. *Sex: *DOB: _____ Age: _____

Marital Status: Primary Language:

*Billing Address: _____ *City: _____ *State: AZ Zip: _____

*Daytime Phone: _____ *Evening Phone: _____

*Referring Physician: _____

Responsible Party/Insurance Information:

*Primary Insurance: _____ *Secondary Insurance: _____

*Policy #: _____ *Policy #: _____

*Group #: _____ *Group #: _____

*Cardholder Name: _____ *Cardholder Name: _____

*DOB: _____ *DOB: _____

SSN: _____ SSN: _____

*Relationship to Patient: _____ *Relationship to Patient: _____

Employer: _____ Employer: _____

Employer Phone #: _____ Employer Phone #: _____

Injury:

Work Related? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No

Date of Injury: _____ Date of Injury: _____

Industrial Ins. Carrier: _____ Auto Ins. Carrier: _____

Phone #: _____ Phone #: _____

Claim #: _____ Claim #: _____

**This form is intended to help with the registration process. Additional forms to fill out may be required at the time of check in.*

PRINT

Revised 01/2015