Hartsdale Imaging
Comprehensive Diagnostic Imaging & Radiology

MEDICAL RECORD NUMBER _____
OFFICE USE ONLY

PATIENT INFORMATION

LAST NAME | MI | FIRST NAME

DATE OF BIRTH | SS # | SELF SPOUSE CHILD OTHER RELATIONSHIP TO GUARANTOR | M F

HOME ADDRESS | APT #

CITY | STATE | ZIP CODE

HOME PHONE | WORK PHONE

CELL PHONE | FAX NUMBER

IF YOU WOULD LIKE TO RECEIVE INFORMATIONAL EMAIL'S FROM HARTSDALE IMAGING PLEASE PROVIDE US WITH YOUR EMAIL ADDRESS BELOW

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PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE INFORMATION FOR INSURED. IF SAME AS PATIENT INFO CHECK HERE ☐

POLICY HOLDERS LAST NAME | POLICY HOLDERS FIRST NAME

DATE OF BIRTH | SS # | SELF SPOUSE CHILD OTHER RELATIONSHIP TO GUARANTOR | M F

SECONDARY INSURANCE INFORMATION

DO YOU HAVE SECONDARY INSURANCE NO ☐ YES ☐ ***IF YES PLEASE GIVE INSURANCE CARD TO SECRETARY***

REFERRING PHYSICIAN INFORMATION

LAST NAME | MI | FIRST NAME

IF YOU WOULD LIKE A COPY OF YOUR RESULTS TO BE SENT TO A SECOND DOCTOR PLEASE COMPLETE BELOW

DOCTORS LAST NAME | MI | DOCTORS FIRST NAME

OFFICE PHONE

IS YOUR VISIT TODAY DUE TO A WORKERS COMPENSATION OR NO-FAULT INJURY ***YES*** ☐ ***NO*** ☐

AUTHORIZATION AND RELEASE

I HEREBY AUTHORIZE ANY PHYSICIAN, HEALTH CARE PRACTITIONER, HOSPITAL, CLINIC OR OTHER MEDICALLY RELATED FACILITY TO FURNISH ANY AND ALL RECORDS, MEDICAL HISTORY, SERVICES RENDERED OR TREATMENT GIVEN TO ME OR ANY DEPENDENT FOR PURPOSES OF REVIEW, INVESTIGATION OR EVALUATION OF ANY CLAIM SUBMITTED TO MY INSURANCE COMPANY.

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS ON MY BEHALF BE MADE DIRECTLY TO HARTSDALE IMAGING / C.C.D.G.L. & S SERVICES INC. , FOR SERVICES RENDERED TO ME.

I AM AWARE THAT I AM FINANCIALLY RESPONSIBLE FOR ANY NON-COVERED SERVICES, ANY INSURANCE DEDUCTIBLE WHICH HAS NOT BEEN MET, AND/OR ANY OUTSTANDING BALANCE FOR SERVICES RENDERED.

_____ _____

SIGNATURE OF PATIENT OR PARENT IF MINOR **DATE**

OFFICE USE ONLY

DOES SCRIPT MATCH AUTHORIZATION ☐ ***YES*** ☐ ***NO IF NO STOP AND CORRECT AUTHORIZATION***