



ATLANTIC RADIOLOGY IMAGING, P.C.

"THE NEW IMAGING REALITY"

Tel. 718-236-6800 • Fax 718-236-4696
105 Kings Highway, Ground Floor, Brooklyn, NY 11214
www.atlanticrad.com

PATIENT INFORMATION

LAST NAME		FIRST NAME	
STREET ADDRESS		APARTMENT #	
CITY	STATE	ZIP CODE	
() HOME PHONE #		() ADDITIONAL PHONE #	
[] MALE [] FEMALE		/ / DATE OF BIRTH (MM/DD/YY)	[] YES [] NO DO YOU SMOKE?
- - SOCIAL SECURITY NUMBER		- AGE	

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY		ID#	
PRIMARY POLICY HOLDER NAME		/ / DOB	RELATIONSHIP
SECONDARY INSURANCE COMPANY		ID#	
SECONDARY POLICY HOLDER NAME		/ / DOB	RELATIONSHIP

EMERGENCY CONTACT INFORMATION

NAME	RELATIONSHIP	PHONE #
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Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible, co-insurance, co-pay or any other balance not paid by your insurance for the procedures performed in our facility.

PLEASE READ AND SIGN THE FOLLOWING:

I directly assign all medical benefits to Atlantic Radiology Imaging, PC and understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize Atlantic Radiology Imaging, PC to release all information necessary to secure the payments. I further agree that a photocopy of this agreement shall be valid as original without expiration date.

SIGNATURE: _____ DATE: _____

[] PATIENT [] GUARDIAN: LIST RELATIONSHIP _____

EMPLOYEE _____