

GREENE MEDICAL IMAGING, P.C.

Greene Medical Arts Center • 159 Jefferson Heights • Catskill, NY 12414

Phone: (518) 943-0212 FAX: (518) 943-0422

Patient Information

X-Ray # _____

Date _____

INSURANCE

PATIENT NAME (FIRST, MIDDLE, LAST) _____

PRIMARY INSURANCE _____

PATIENT'S STREET ADDRESS _____

NAME OF POLICY HOLDER _____

CITY, STATE _____ ZIP _____

INSURANCE STREET ADDRESS _____

DATE OF BIRTH _____ AGE _____ SEX _____ SOC. SEC. NO. _____

CITY, STATE _____ ZIP _____

MARITAL STATUS _____ HOME PHONE _____ WORK PHONE _____

POLICY # _____ GROUP # _____

ARE YOU: ACTIVELY EMPLOYED RETIRED

SECONDARY INSURANCE _____

EMPLOYER _____ EMPLOYER'S PHONE _____

NAME OF POLICY HOLDER/RELATIONSHIP _____

EMPLOYER STREET ADDRESS _____

INSURANCE STREET ADDRESS _____

CITY, STATE _____ ZIP _____

CITY, STATE _____ ZIP _____

OCCUPATION (INDICATE IF STUDENT) _____

POLICY # _____ GROUP # _____

FILL IN FOR HUSBAND OR WIFE

FILL IN IF PATIENT IS A MINOR

SPOUSE'S NAME _____

FATHER'S NAME (FIRST, MIDDLE, LAST) _____

IS SPOUSE: ACTIVELY EMPLOYED RETIRED

EMPLOYER _____ EMPLOYER'S PHONE _____

EMPLOYER _____ EMPLOYER'S PHONE _____

EMPLOYER STREET ADDRESS _____

EMPLOYER STREET ADDRESS _____

CITY, STATE _____ ZIP _____

CITY, STATE _____ ZIP _____

MOTHER'S NAME (FIRST, MIDDLE, LAST) _____

EMPLOYER _____ EMPLOYER'S PHONE _____

EMPLOYER STREET ADDRESS _____

CITY, STATE _____ ZIP _____

I certify that the information given by me is correct. I authorize GREENE MEDICAL IMAGING, P.C. to obtain and release any and all data that is essential to my medical treatment and testing, and payment thereof. Should this claim be rejected by the payors, I fully understand that I am responsible for payment. I also authorize the release of any and all information contained in the medical record of _____ (patient) to any insurance plan or governmental body having responsibility for review and/or payment for care provided me.

In consideration of the services provided to (patient) I hereby assign and authorize payment directly to GREENE MEDICAL IMAGING, P.C. I hereby consent to the rendering of medical care which would include procedures and tests.

PATIENT'S SIGNATURE _____ DATE _____

PARENT'S SIGNATURE (IF MINOR) _____ DATE _____