CITY WIDE HEALTH FACILITY, INC.
RADIOLOGY DEPARTMENT

Tel. 718-236-6800 Fax 718-236-4696
105 Kings Highway, Ground Floor, Brooklyn, NY 11214
www.citywideradiology.com
E-mail: citywideradiology@gmail.com

PATIENT INFORMATION

LAST NAME FIRST NAME

STREET ADDRESS APARTMENT #

CITY STATE ZIP CODE

(________)__________________ (__________)________________________________
HOME PHONE # ADDITIONAL PHONE #

[ ]MALE______[ ]FEMALE______________________/_______/__________________________[ ]YES______[ ]NO________
DATE OF BIRTH (MM/DD/YY) 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 #

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_________