

**DEMOGRAPHIC INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Patient ID \_\_\_\_\_  
 Sex \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Ht \_\_\_\_\_ Wt \_\_\_\_\_ Maiden/Previous Name \_\_\_\_\_ First language spoken: \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Zip Code \_\_\_\_\_ Home Ph.# \_\_\_\_\_ Work Ph.# \_\_\_\_\_ Cell # \_\_\_\_\_  
 Primary Care Physician \_\_\_\_\_ Address \_\_\_\_\_  
 Referring Physician \_\_\_\_\_ Address \_\_\_\_\_  
 Employer Name \_\_\_\_\_ Employer Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Business Phone \_\_\_\_\_

**EMERGENCY CONTACT/ GUARANTOR INFORMATION**

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Ph.# \_\_\_\_\_ Work Ph.# \_\_\_\_\_ Cell # \_\_\_\_\_

**INSURANCE INFORMATION**

<u>Primary Insurance</u>	<u>Secondary Insurance</u>
Insurance Name _____	Insurance Name _____
Address _____	Address _____
Phone # _____	Phone # _____
Relationship of Patient to Subscriber _____	Relationship of Patient to Subscriber _____
Subs. Name _____	Subs. Name _____
Subs. Date of Birth _____	Subs. Date of Birth _____
Subs. SSN _____ - _____ - _____	Subs. SSN _____ - _____ - _____
Subs. Employer _____	Subs. Employer _____
Subs. Employer City/ State _____	Subs. Employer City/ State _____
Policy # _____ Group # _____	Policy # _____ Group # _____

**Is this visit Work Related? Yes / No      Is this visit related to an auto accident? Yes / No**

Insurance Name \_\_\_\_\_ Date of Injury/ Accident \_\_\_\_\_  
 Adjuster Name/ Phone # \_\_\_\_\_ Claim # \_\_\_\_\_

**AUTHORIZATION ▪ FINANCIAL POLICY ▪ RECEIPT OF PRIVACY PRACTICES- Please initial each line**

\_\_\_\_\_ To complete my insurance claim and treatment, I hereby assign all benefits to the New Jersey Institute of Radiology, PC (NJIR) and I acknowledge that I am responsible for any balance not covered by those benefits. I authorize NJIR to release my medical records to insurers paying such benefits, my physician (s), clinic or hospital.

\_\_\_\_\_ I have provided NJIR with full and complete insurance information. NJIR will automatically file the claim for me. If my insurance company denies payment because the necessary information was not provided, I will be responsible for the payment of my bill. NJIR will bill me for all applicable deductibles and copays. I agree to pay for all non-covered services not paid by my insurance.

\_\_\_\_\_ I understand that I must provide written authorization to allow NJIR to release medical records (films, CDs or reports) to anyone other than my physician or insurance company.

\_\_\_\_\_ I acknowledge that I have received a copy of NJIR's Notice of Privacy Practices.

\_\_\_\_\_ I have read the all of the above and acknowledge that the information is current and accurate.

**Signature of Patient or Representative** \_\_\_\_\_ **Date** \_\_\_\_\_