Radiology Associates of Brooklyn, LLP

(718) 332-6800

ALLEN B. ZELMAN, M.D.
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Today's Date: ___________

Have you ever been here before ❑ yes ❑ no

Patient's Last Name ______________________ First ______________________

Address ____

City ______________________ State ____________________ Zip ___________

Home Telephone ________________ Business ______________________

Sex ___________ Birthdate ____________ SS# __________________

Employer ______________________________ Telephone __________________

Employer Address ____

Referring Doctor ______________________________ Telephone ______________

Address ____

City ______________________ State ________________ Zip ________________

Primary Insurance __________________________ Group # ___________

Policy Number ____________________

Relationship to Patient ____________________________

Secondary Insurance ____________________________

Policy Number ______________

Nearest Relative __________________________ Telephone # ________________

Is there any chance you might be pregnant _______ Last period _________

Payment is expected at time of service, unless other arrangements have been made.

I hereby authorize payment of medical benefits to undersigned Physician for services rendered

____

I hereby authorize the release of any medical information necessary to process this claim

____

(over)

No Fault Insurance

Insured ________________________________ Date of Accident __________________

Insurance ____ Policy # _______________

Address ____________________________________ Claim # ____________________

Phone ______________________

Lawyer _________________________________ Telephone _____________________

Address ____

Workman's Compensation

Written Authorization ❑ Yes ❑ No

Employer ___________________________________ Phone ____________________

Insurance _____________________________ Case # _________________________

Address ____

Phone _______________________ Verbal Approval ❑ Yes ❑ No

If patient is a minor:

The name of legal guardian responsible for medical bills _________________________

If patient is a student:

Name of school ____

Signature on File

❑ I authorize use of this form on all my insurance submissions

❑ I authorize release of information to all my insurance companies

❑ I understand that I am responsible for my bill

❑ I understand that I am responsible for any annual deductible

❑ I permit a copy of this authorization to be used in place of the original

Date ______________ Name (print) _____________________________

Signature ___________________________________