RAH
RADIOLOGY ASSOCIATES OF HARTFORD, P.C.

LOCATION: ☐ Avon 860-409-1952 ☐ Enfield 860-714-9410 ☐ Glastonbury 860-714-9710

Patient Information

_____
Account Number
(Office use only)

AGE: _____

PATIENT NAME: _____ SEX: _____
Last First Middle Initial

Address: _____
Number Street Apt. #

City: _____ State: _____ Zip Code: _____

Telephone: _____ _____ _____
Home Business Ext.

Date of Birth: _____ Social Security #: _____

Employed By: _____
Company Name Address Telephone

Spouse's Name: _____

Referring Physician: _____ Office Location: _____
(City, State)

Email Address: _____ How did you hear about us?: _____

Medical Insurance Information

1. Name of Carrier: _____ Identification Number: _____

2. My insurance is in: ☐ My Name ☐ Spouse's Name ☐ Parent's Name

3. Spouse or Parent's Date of Birth: _____ / _____ / _____

4. Spouse's or Parent's Employer: _____

_____
Address

5. Are you covered under any other insurance plan? If so, please indicate:

Name of Carrier: _____ Subscriber Number: _____

Assignment of Physician's Benefits

I hereby authorize payment directly to RADIOLOGY ASSOCIATES OF HARTFORD, P.C., of the professional fees associated with radiological procedures and/or surgical benefits, if any, otherwise payable to me for its services. I hereby authorize the above physicians to release any information acquired in the course of my examination or treatment necessary for billing purposes.

I understand that I am financially responsible for the charges not covered by this authorization.

Date: _____ Signed: _____