RADIOLOGY ASSOCIATES of HARTFORD, P.C.

Avon • 35 Nod Road
Enfield • 9 Cranbrook Blvd
Glastonbury • 31 Sycamore Street
Bloomfield • 673 Cottage Grove Road

Phone: (860) 969-6400
Fax: (860) 714-8808

Patient Information

_____ **Age:** _____

Account #: (Office use only) **Sex:** _____

Patient Name: _____
Last First Middle Initial

Address: _____
Number Street Apt. #

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ _____ _____
Home Business Ext.

Date of Birth: _____ **Social Security #:** _____

Employed By: _____
Company Name Address Phone

Spouse's Name: _____

Referring Physician: _____ **Office Location:** _____
City, State

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

MEDICAL INSURANCE INFORMATION

Name of Carrier: _____ **Identification #:** _____

My insurance is in: ☐ My name ☐ Spouse's name ☐ Parent's name

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

Spouse's or Parent's Employer: _____

_____
Address

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

Name of Carrier: _____ **Subscriber #:** _____

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: _____