



# NEXT GENERATION RADIOLOGY

GREAT NECK  
560 Northern Blvd.  
516-504-1600  
PET 516-482-2135

PORT JEFFERSON STATION  
4 Medical Drive  
631-928-1600

GARDEN CITY PARK  
2403 Jericho Tpke.  
516-248-3210

www.nextgenerationrad.com

Name first middle initial last

Date of Birth (mm/dd/yyyy) SS# - - Sex: M F

Address street

city state zip Home Phone ( )

Employer's Name Work Phone ( )

Referring Physician First & Last Name Physician Phone ( )

Referring Physician Address

Emergency Contact Relationship To Patient Phone ( )

How Did You Hear About Us? Referring Doctor Family Member Friend Other: \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance Company Phone ( )

Insurance Address

Policy or ID # Group #

Insured's Name Relationship to Patient: Self Spouse Dependent

Insured's Date of Birth (mm/dd/yyyy) SS# - - Sex: M F

Insured's Employer Name Insured's Employer Phone ( )

Insured's Employer Address

## SECONDARY INSURANCE INFORMATION (if applicable)

Insurance Company Phone ( )

Insurance Address

Policy or ID # Group #

Insured's Name Relationship to Patient: Self Spouse Dependent

Insured's Date of Birth (mm/dd/yyyy) SS# - - Sex: M F

I hereby assign, transfer, and set over to Next Generation Radiology all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. *I understand that I am financially responsible for all charges whether or not they are covered by insurance.*

PATIENT/GUARDIAN SIGNATURE DATE

### OFFICE USE ONLY

ADS ACCT# DHT MRN#

AUTH# EXAM