Winthrop Radiology Associates, P.C.

Print out must be legible

Today's Date_____

Name_____ ☐ Male ☐ Female

Date of Birth____/____/_____ Social Security #_____/____/_____

Address_____

Home Phone#_____ Cell#_____

Marital Status:
☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Married Spouse's Name_____

INSURANCE INFORMATION

Primary Insurance _____ Subscriber Name _____

Subscriber Employer_____ Employer Address_____

Employer Tel #_____ Relationship to Insured_____

Secondary Insurance Name _____ Subscriber Name_____

Subscriber Employer_____ Employer Address_____

Employer Tel #_____ Relationship to Insured_____

Guarantor Information _____SELF _____*OTHER

*Name_____*Date of Birth____/____/_____

*Address_____

*Social Security #_____/____/_____ Phone#_____

AUTHORIZATION NUMBER (if needed)_____none needed ( )

IN CASE OF EMERGENCY – AUTHORIZED CONTACT PERSON

Full Name_____

Home Phone#_____ Cell#_____

I VERIFY THE ACCURACY OF THE ABOVE INFORMATION

PATIENT OR AUTHORIZED SIGNATURE_____ DATE_____

☐ I acknowledge that I have read the Winthrop Radiology Associates HIPAA Privacy Notice.