



# PATIENT INTAKE FORM

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ Work/Cell Phone: (\_\_\_\_) \_\_\_\_\_

### PRIMARY INSURANCE

Insurance Co. Name: \_\_\_\_\_  
 Policyholder's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship: \_\_\_\_\_

### SECONDARY INSURANCE

Insurance Co Name: \_\_\_\_\_  
 Policyholder's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship: \_\_\_\_\_

### INSURANCE ASSIGNMENT OF BENEFITS

I, \_\_\_\_\_ Member ID# \_\_\_\_\_

REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE TO RIVER RADIOLOGY, PLLC, FOR ANY SERVICES FURNISHED TO ME BY THE PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE COMPANY(S) ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
 Witness: \_\_\_\_\_ Date: \_\_\_\_\_

### MEDICARE ASSIGNMENT OF BENEFITS

I, \_\_\_\_\_ Medicare# \_\_\_\_\_

REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE TO RIVER RADIOLOGY, PLLC, FOR ANY SERVICES FURNISHED TO ME BY THE PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE COMPANY(S) ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
 Witness: \_\_\_\_\_ Date: \_\_\_\_\_