



# 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: \_\_\_\_\_