AMDS+ RADIOLOGY

2025 RICHMOND AVENUE, STATEN ISLAND, NY 10314
PHONE: 718.494.0800 FAX: 718.494.4066

+ PATIENT INFORMATION

LAST NAME: ____________________ FIRST: ____________________ MIDDLE : __________

☐ MR. ☐ MISS ☐ MRS. ☐ MS. marital status: ☐ SNGL ☐ MAR ☐ DIV ☐ SEP ☐ WID

IS THIS YOUR LEGAL NAME? ☐ YES ☐ NO - WHAT IS? ______________ FORMER NAME? ______________

DATE OF BIRTH: ____________________ AGE: __________ SEX: ____________________

STREET ADDRESS: ____________________ CITY: ______________ ST: ______ ZIP: ______________

SOCIAL SECURITY # : ____________________ HOME PHONE: ____________________

TYPE OF EXAM (MRI, CT, ULTRASOUND, XRAY): ____

REASON FOR EXAM (SYMPTOMS): ____

EMERGENCY CONTACT NAME: ____________________ PHONE #: ____________________

EMPLOYER : ____________________ PHONE #: ____________________

HAVE YOU BEEN TO THIS FACILITY BEFORE? ☐ Y ☐ N DO YOU CURRENTLY SMOKE? ☐ Y ☐ N

IF YOU DID SMOKE, QUIT DATE? ____

REFERRING PHYSICAN'S NAME: ____________________ PHONE #: ____________________

ADDRESS: ____

PRIMARY CARE PHYSICIAN: ____________________ PHONE #: ____________________

INSURANCE ☐ Y ☐ N NAME ____________________ ADDRESS: ____________________

CARRIER PHONE #: ____________________ EFFECTIVE DATE: ____________________

SUBSCRIBER'S NAME: ______________ SOCIAL SECURITY #: ______________ DOB: __________

POLICY #: ______________ GROUP #: ____________________ CO-PAY/DEDUCTIBLE $ ______________

PATIENT'S RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER: __________

NAME OF SECONDARY INSURANCE/ADDRESS (if applicable): ____________________

SUBSCRIBER'S NAME: ______________ POLICY #: ______________ GROUP #: ______________

PATIENT'S RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER: __________

PRE-AUTHORIZATION/REFERRAL REQUIRED: PRE-AUTH: ☐ YES ☐ NO REF: ☐ YES ☐ NO

PRE-AUTH #: ____________________ REF ON FILE/NUMBER: ____________________

NON MEDICARE PATIENTS: I authorize AMDS, PC to release any medical or other information necessary to process this claim and I authorize the payment by any third party payers to AMDS,PC to release reports of my exam and/or copies of my studies to my referring and/or requesting physicians upon their request. I agree and understand that I am responsible for any costs incurred in collection of any outstanding balances.

SIGNATURE: ____________________ DATE: ____________________

MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made either to me or on my behalf to to AMDS, PC for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, and its agents any information needed to determine these benefits or the benefits payable for related services. I agree and understand that I am responsible for any costs incurred in collection of any outstanding balances.

SIGNATURE: ____________________ DATE: ____________________