WASHINGTON RADIOLOGY ASSOCIATES, P.C.

PATIENT INFORMATION

pi

ACCT#_____ DATE_____

NAME Last	First	M.I.	SOC. SEC. NUMBER	DATE OF BIRTH	AGE	SEX	MARITAL STATUS
						☐ M ☐ F	☐ S ☐ M ☐ W ☐ D

ADDRESS Street	Apt. No.	City	State	Zip	HOME PHONE	WORK PHONE
					( )	( )

REFERRING PHYSICIAN'S NAME & ADDRESS	Street	City	State	Zip	OCCUPATION	IF STUDENT
						☐ F/T ☐ P/T

PRIMARY CARE PHYSICIAN'S NAME & ADDRESS	Street	City	State	Zip	EMPLOYER OR SCHOOL NAME

LAST MENSTRUAL PERIOD DATE	ONSET OF SYMPTOM(S) DATE	IS THIS VISIT RELATED TO ☐ EMPLOYMENT (CURRENT OR PREVIOUS)	☐ AUTO ACCIDENT If Yes, State_____	☐ OTHER ACCIDENT DATE OF ACCIDENT_____

PERSON FINANCIALLY RESPONSIBLE (if other than patient)

NAME Last	First	M.I.	SOC. SEC. NUMBER	DATE OF BIRTH	HOME PHONE
					( )

ADDRESS Street	Apt. No.	City	State	Zip	WORK PHONE
					( )

PRIMARY INSURANCE INFORMATION

INSURANCE CO. NAME & ADDRESS	Street	City	State	Zip	POLICY NUMBER	GROUP #

PATIENT RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ Other _____	INSURED'S SOCIAL SECURITY NUMBER	INSURED'S HOME PHONE
		( )

INSURED'S NAME & ADDRESS	Street	City	State	Zip	DATE OF BIRTH	SEX
						☐ M ☐ F

INSURED'S EMPLOYER NAME & ADDRESS	Street	City	State	Zip	INSURED'S WORK PHONE
					( )

SECONDARY INSURANCE INFORMATION

INSURANCE CO. NAME & ADDRESS	Street	City	State	Zip	POLICY NUMBER	GROUP #

PATIENT RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Child ☐ Other _____	INSURED'S SOCIAL SECURITY NUMBER	INSURED'S HOME PHONE
		( )

INSURED'S NAME & ADDRESS	Street	City	State	Zip	DATE OF BIRTH	SEX
						☐ M ☐ F

INSURED'S EMPLOYER NAME & ADDRESS	Street	City	State	Zip	INSURED'S WORK PHONE
					( )

All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage.

Patient's Authorization

I,_____, hereby authorize Washington Radiology Associates, P.C. to apply for benefits on my behalf for services rendered by WRA I request that the payments from Medical Service of D.C./Medicare and/or any independent carrier that WRA contractually participates with or any other insurance company be made directly to WRA. I certify that the insurance information provided is correct.

I authorize the release of any necessary information, including medical information for this or any related claim, to the above insurance company, Medical Service of D.C., Medicare (which may include the Social Security Administration, Centers for Medicare & Medicaid Services or its intermediaries), which Washington Radiology Associates, P.C. contractually participates or any other independent carrier.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier at any time in writing.

_____ _____ _____

Signature of Patient/Subscriber | Social Security Number | Date

I have received a copy of WRA's Notice of Privacy Practices. _____ Patient Declined

_____ _____ _____ _____

Patient's Printed Name | Patient's Signature | Date | Pt Declined - Employee Signature