RYE RADIOLOGY
Dedication • Expertise • Technology

30 Rye Ridge Plaza
Rye Brook, NY 10573
914-253-9200 or 1-877-RYE-RADS

Account #_____(To be completed by Rye Radiology)

ENCOUNTER FORM

Please provide us with the following information to enable us to maintain accurate records. Please complete form and bring to your appointment.

Patient's Name: _____ _____
Last First

Address: _____ Social Security #:: _____

_____ Birth Date: _____

Home Phone #:_____ Business Phone #:_____

Employer:_____

Address: _____

E-Mail Address: _____

Responsible Party Information:

Address: _____ Relationship: _____

_____ Phone #:_____

Referring Physicians(s): Please list all physicians that should receive a copy of your medical report.

1. Name:_____

   Address:_____

2. Name:_____

   Address:_____

3. Name:_____

   Address:_____

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Medical Insurance: Please enter Responsible Party Information (if applicable)

Please enter your insurance information:

Insurance Company: _____ Policy Number: _____

Address: _____ Soc.Sec.#_____

Group Number: _____ Birthdate Policyholder: _____

Insured Party's Employer: _____

Insured Party's Relationship to Patient:_____

Secondary Insurance:

Insurance Company: _____ Policy Number: _____

Address: _____ Soc.Sec.#_____

Group Number: _____ Birthdate Policyholder: _____

Insured's Party Employer: _____

Insured Party's Relationship to Patient: _____

I hereby authorize Rye Radiology to furnish information to any Insurance Carrier concerning my illness and treatments and hereby assign Rye Radiology Assoc., LLP, payments for medical services rendered to myself or dependents. I understand that I am responsible for any amount not covered by insurance.

Patient's Signature:_____

Date: _____

Please complete form and bring to your appointment.