ColumbiaDoctors | *Radiology*

212-326-8518
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PATIENT DEMOGRAPHIC SHEET

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt. #: _____ City: _____

State: _____ Zip: _____ Email: _____

Home Tel. #: _____ Business Tel. #: _____

Referring M.D.: _____ M.D.'s Tel. #: _____

Doctor's Address: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Marital Status: (CHECK ONE) ☐ Married ☐ Single ☐ Widow ☐ Divorced ☐ Separated

Language: _____ Race: _____ Ethnicity: _____

Mother's First Name: _____ Father's First Name: _____

Employer: _____ Address: _____

AUTHORIZATION FOR RELEASE OF MEDICAL BENEFITS AND PAYMENT AGREEMENT

*****ALL PATIENTS (including Medicare Patients): PLEASE READ AND SIGN**

I verify the accuracy of the information provided on the Patient Demographic Sheet and authorize release of information necessary to process any claims. I also understand that this facility may not participate with my insurance and I am therefore responsible for payment. If my insurance is one that this facility participates in I request payment of claims directly to this facility. I understand that I am ultimately responsible for all services. Additionally, I will be responsible for all balances after insurance payments. I will work with the Doctor's office to have Worker's Compensation and/or No Fault claims paid to the Doctor, and I understand that all bills are my responsibility if not paid by the carrier.

_____ _____
Signature of Patient or Authorized Agent Date

_____ _____
Print Name Unit #

MEDICARE – SIGNATURE ON FILE

******ALL MEDICARE PATIENTS: PLEASE READ AND SIGN**

I request that payment of authorized Medicare benefits be made to my physician for any services furnished me by the physician. I authorize any holder of my medical information to release what is needed to determine these benefits or the benefits payable for related services to the Health Care Financing Administration and its agents.

_____ _____
Signature of Patient Date

_____ _____
Print Name Unit #