



**MANHATTAN DIAGNOSTIC RADIOLOGY**

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**PATIENT REGISTRATION FORM**

UNIQUE ID# : \_\_\_\_\_  
(FOR INTERNAL USE)

Please print legibly

DATE: \_\_\_\_\_

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ M.I.: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE #: \_\_\_\_\_ WK PHONE #: \_\_\_\_\_ CELL PHONE #: \_\_\_\_\_ EMAIL : \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: M  F  SOCIAL SECURITY #: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

REFERRING PHYSICIAN PHONE #: \_\_\_\_\_ REFERRING PHYSICIAN FAX #: \_\_\_\_\_

REFERRING PHYSICIAN ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

COPY TO: \_\_\_\_\_ PHONE#: \_\_\_\_\_ FAX #: \_\_\_\_\_

COPY TO ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

COPY TO: \_\_\_\_\_ PHONE#: \_\_\_\_\_ FAX #: \_\_\_\_\_

COPY TO ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

COPY TO: \_\_\_\_\_ PHONE#: \_\_\_\_\_ FAX #: \_\_\_\_\_

COPY TO ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**PRIMARY INSURANCE COVERAGE**

NAME OF INSURANCE: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_

INSURANCE ID#: \_\_\_\_\_ GROUP #: \_\_\_\_\_ GROUP NAME: \_\_\_\_\_

POLICYHOLDER NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

IF POLICYHOLDER IS OTHER THAN PATIENT, PLEASE COMPLETE THE FOLLOWING INFORMATION ON THE POLICYHOLDER:

SOCIAL SECURITY #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**SECONDARY INSURANCE COVERAGE**

NAME OF INSURANCE: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_

INSURANCE ID#: \_\_\_\_\_ GROUP #: \_\_\_\_\_ GROUP NAME: \_\_\_\_\_

POLICYHOLDER NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

IF POLICYHOLDER IS OTHER THAN PATIENT, PLEASE COMPLETE THE FOLLOWING INFORMATION ON THE POLICYHOLDER:

SOCIAL SECURITY #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

I ATTEST THAT TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

***(For Internal Use)***

PATIENT ACCOUNT NUMBER: \_\_\_\_\_ APPOINTMENT TIME: \_\_\_\_\_ AM  PM

ARRIVAL: \_\_\_\_\_ PAPERWORK: \_\_\_\_\_ DATA ENTRY: \_\_\_\_\_ BY: \_\_\_\_\_ DRINK: \_\_\_\_\_

STUDIES: \_\_\_\_\_

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

AMOUNT: \_\_\_\_\_ AMOUNT PAID: \_\_\_\_\_ CASH  CHECK  CREDIT CARD  BALANCE: \_\_\_\_\_