



**QUAKERBRIDGE**  
RADIOLOGY

# New Patient Form

Patient name \_\_\_\_\_

Date of birth \_\_\_\_\_

Referring physician \_\_\_\_\_

Please list any other doctor(s) who should receive your report:

\_\_\_\_\_  
\_\_\_\_\_

(If the doctor is not in our area, please provide an address or phone number.)

**PLEASE FILL OUT IF THE INSURANCE IS NOT UNDER THE PATIENT'S NAME**

Subscriber name \_\_\_\_\_

Date of birth \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

Do you have an advance directive (living will)?     Yes     No

If yes, do we have a copy for our records?     Yes     No

I hereby authorize release of medical records to insurance companies in order for payment to be made. I assign to Quakerbridge Radiology Associates at Quakerbridge Plaza payment of benefits for me to cover medical expenses. I agree that should the amount be insufficient to cover the entire medical expenses, I will be responsible for the payment of the difference. I also authorize the release of my medical records to any and all licensed health care providers involved with my healthcare. I understand that if I am scheduled for an MRI exam and I cannot complete the exam due to claustrophobia, I will be charged \$35.00 for table time.

Signature \_\_\_\_\_ Date \_\_\_\_\_