DDI
Distinguished Diagnostic Imaging P.C.

John T. Rigney, M.D.
Board Certified Radiologist

MRI • BONE DENSITOMETRY • X-RAY • ULTRASOUND • MAMMOGRAPHY • CT SCAN

REGISTRATION FORM

1484 Williamsbridge Road
Bronx, New York 10461
Tel: 718.828.6800
Fax: 718.828.6586
www.ddiimaging.com

Type of Exam:	
Acct. No.:	**Date:**

Last Name:	**First Name:**	
Address:		**Apt:**
City:	**State:**	**Zip Code:**
Home Number: ( )	**Cell Number:** ( )	**Work Number:** ( )
Date of Birth:____/____/_____	**Age:**	**Gender: ___ Male __ Female**
Social Security Number: ___________- _____-___________		

REFERRING PHYSICIAN

Physician's Name:			Specialty:
Address:			Office Number:
City:	State:	Zip Code:	Fax Number:

PRIVATE INSURANCE INFORMATION

PRIMARY

Carrier:	Policy No.:
Policy Holder:	Group No.:
Phone No.:	Relationship:

SECONDARY

Carrier:	Policy No.:
Policy Holder:	Group No.:
Phone No.:	Relationship:

EMERGENCY CONTACT

Name:	**Relationship:**
Home Number :	**Alternate Number:**

CO-PAYMENTS

Cash: ___________	Check: ___________	Other: ___________

I hereby authorize payment of medical benefits to this physician for services described above. I also authorize the release of any information necessary to process this claim.

Signature:	**Date:**

CONT. →

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

______________________________ ______________

Print Name **Date**

______________________________ ______________

Name of Parent or Authorized Representative Date
(If patient is a minor or unable to sign for themselves)

______________________________ ______________

Signature **Date**