RRC Reston Radiology Consultants

Patient Information Questionnaire

Patient's Legal Name (L, F, MI)			Date
Birth Date	Sex (M, F)	Home Phone	Work Phone
Address		City/State/Zip	
Employer		Occupation	
Social Security		E-Mail	
Referring Physician	Date of Onset	Symptons	

Responsible Parties Information *(If Different from patient)*

Responsible Party	Relationship	Birth Date
Social Security Number	E-Mail	
Responsible Parties Address	City/State/Zip	Home Phone
Employer		Work Phone

Primary Insurance

Insurance Company	ID Number	Group Number
Insured	Birth Date	Employer
Relationship to Patient	Treatment Authorization	

Secondary Insurance

Insurance Company	ID Number	Group Number
Insured:	Birth Date	Employer
Relationship to Patient	Treatment Authorization	

Authorization and Assignment

I certify that the information I have reported with regard to insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim in order to determine benefits, which I may be entitled. I permit a copy of this authorization to be used in place of the original.

I hereby authorize payment directly to the facility for benefits or otherwise payable to me under the terms of my policy but not to exceed my indebtedness to said physician for services as described hereon. In making this assessment to the physician, I understand and agree that any unpaid balance not covered by this policy will be billed to me.

Signature of Subscriber/Beneficiary **Date**