Lerman Diagnostic Imaging
6511 Fort Hamilton Parkway • Brooklyn, NY 11219
Tel: 718 491-4545 • Fax: 718 491-4123

PATIENT ENCOUNTER FORM

Appt. Time	Today's Date	Patient Number	Init.
	/ /		

Patient Last Name	First Name
Birth Date / /	Social Security No.
Address	
City	State
Zip Code	Telephone

Sex ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Pregnant ☐ Yes ☐ No

Referring Physician	Phys. Phone No.
Referring Physician's Address	

Has Patient Had X-Rays Here Before? ☐ Yes ☐ No

INSURED'S INFORMATION

Patient's Relationship To Insured ☐ S - Self ☐ D - Dependant ☐ O - Other ☐ P - Spouse ☐ C - Child

Insured's Last Name	First Name
Insured's Birth Date / /	Insured's Social Security No.
Insured's Address	
City	State
Zip Code	Telephone

Sex ☐ Male ☐ Female

Name of Insured's Employer	
Address	
City	State
Zip Code	Telephone

INSURANCE INFORMATION

Medicare Number	Medicaid Number
GHI Certificate Number	GHI Pre-Cert. Number
Group Number	Category Number
Other Insurance Coverage	
Address	
City	State
Zip Code	Telephone
I.D. Number	Policy Number

Exam(s):

Reason for Exam(s):

Complaint:

Copy to Dr.(s):

AUTHORIZATION TO RELEASE INFORMATION & PAYMENT REQUEST

INSURANCE BILLING: I HEREBY AUTHORIZE LERMAN DIAGNOSTIC IMAGING TO FURNISH MY INSURANCE COMPANY ALL INFORMATION WHICH THE INSURANCE COMPANY MAY REQUEST CONCERNING MY PRESENT ILLNESS OR INJURY.

DATE:_____ SIGNATURE:_____

I HEREBY ASSIGN TO LERMAN DIAGNOSTIC IMAGING ALL INSURANCE BENEFITS, INCLUDING MAJOR MEDICAL AND MEDICARE, TO WHICH I AM ENTITLED. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE AS VALID AS THE ORIGINAL.

DATE:_____ SIGNATURE:_____

VALUABLES: I UNDERSTAND THAT LERMAN DIAGNOSTIC IMAGING IS NOT RESPONSIBLE FOR LOSS OR DAMAGE TO, OR THEFT OF MY PERSONAL POSSESSIONS WHILE I AM ON LERMAN DIAGNOSTIC IMAGING PREMISES.

DATE:_____ SIGNATURE:_____

INSURANCE PRE-CERT. NUMBER(S):_____