**Today's Date**: ……/…../…… **Name**……
*Last* *First*

**Date of Birth** ……/……/…….. **Social Security** ……...-…….-…… ***Are you the insured? Y / N***

Address ……..

……

Apt # ……

City ……State ……Zip ……..

**Phone** *(Home)*……..

*(Wrk)*…….

*(Cell)*…….

**Email** ……..

**Primary Insurance**……..**ID#**.....

**Second Insurance** ……...**ID#** …….

*If any Insurance is Medicare, is the coverage through a* ***Medicare Advantage HMO*** ***Y / N***

***I hereby request the results of my test done today to be sent to my Physician at :***

*First*_____

*Second*_____

……
***Physician Name*** ***Address*** ***Phone*** ***Fax***

***I hereby acknowledge the receipt of UDMI HIPAA policy :*** **Signed X**……..

**University Diagnostic Medical Imaging, P.C.** *1200 Waters Place Suite M108 Bronx, NY 10461 718 931 5620 Fax 718-824-0706*

Please complete the fields above to the best of your ability. Note*: A new registration form is required for each date of service*

Please bring a copy of any documents your physician gave you regarding the exam(s) you are having performed at UDMI