**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***

**Is the patient Enrolled in, or Living in any of the following:**

*Please check any or all that apply*

**Nursing Home** ☐ **Rehabilitation Center *"In patient"*** ☐ **Hospice or Hospice Program** ☐ **None** ☐

*Please explain:*

The Doctors of University Diagnostic Medical Imaging want to give you the best care. Please tell us why you are here for studies,
What is your health problem?.........

***I hereby request the results of my exams performed today, to be sent to my Physician(S) at :***

*CODE*

☐ Ordering

..........................................................................................................................................

☐ Specialist or Other

..........................................................................................................................................

*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*