

COLUMBUS CIRCLE IMAGING

A division of West Side Radiology Associates, P.C.

1790 Broadway New York, N.Y. 10019 .Tel :(212) 977-4100

Section I : Patient Information

Name: _____

Date of Birth: _____ **SS#** _____

Address: _____

City/State/Zip: _____

Home Telephone: _____ **Work Phone:** _____

Section II : Referring Physician:

Name: _____

Address: _____

Telephone: _____ **Fax Number:** _____

Section III: Insurance Information:

Primary Insurance Carrier: _____

Address: _____

I.D. #: _____

Telephone: _____

Primary Insured: _____ **Relationship:** _____

Secondary In Carrier: _____

Secondary Insured: _____ **Relationship:** _____

Section IV (For Personnel Only)

Receptionist: _____

Preauthorization: _____