MAGNETIC DIAGNOSTIC RESOURCES OF CENTRAL NEW YORK, LLP

PATIENT DEMOGRAPHICS

Patient Name (Last, First, Middle)	Parent/ Legal Guardian _____ Relationship to Patient
Date of Birth _____ Email	Date of Birth _____ Email
Street Address	Street Address
City, State, Zip Code	City, State, Zip Code
Home Phone _____ Cell Phone	Home Phone _____ Cell Phone

NO FAULT INSURANCE INFORMATION

Auto Accident Injury (NO FAULT)? Yes☐ No ☐

Date of Auto Accident: _____/_____/_____

Insurance Carrier

Address/City/State/ZIP

Claim #

Insurance Representative _____ Phone Number

WORKER'S COMPENSATION INFORMATION

Workplace Injury (WORKER'S COMP)? Yes☐ No ☐

Date of Worker's Comp Injury: _____/_____/_____

Employer and Address

Insurance Carrier and Address

Claim #

Insurance Representative _____ Phone Number

INSURANCE INFORMATION - No need to fill out if we made a copy of your card(s).

Primary Insurance Carrier _____ Effective Date	Secondary Insurance Carrier _____ Effective Date
Policy Holder Name	Policy Holder Name
Subscriber ID # _____ Group #	Subscriber ID # _____ Group #
Relationship to Patient _____ Policy Holder Employer	Relationship to Patient _____ Policy Holder Employer

1. I have been offered a copy of the *Notice of Privacy Practices* at Magnetic Diagnostic Resources of CNY, LLP and have been given the opportunity to read and ask questions.
   Authorized Signature: X_____ Date: X _____

2. As per *Notice of Privacy Practices*, I authorize the release of information for treatment, payment, healthcare operations, and contacting you.
   Authorized Signature: X_____ Date: X _____

3. I authorize my insurance benefits to be paid directly to Magnetic Diagnostic Resources of CNY, LLP and I acknowledge that I am financially responsible for any co-payment, deductibles, and non-covered services.
   Authorized Signature: X_____ Date: X _____