RICHMOND HILL RADIOLOGY
116-14 MYRTLE AVENUE (RHR)
RICHMOND HILL, NY 11418
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PHONE (718) 846-0606
FAX (718) 846-8684
www.richmondhillradiology.com

KISSENA RADIOLOGY (KRA)
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FLUSHING, NY 11355
(CORNER OF MAIN STREET)
PHONE (718) 321-2849
FAX (347) 438-1600
www.kissenaradiology.com

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SERVING NEW YORK CITY COMMUITY'S IMAGING NEEDS SINCE 1955 (RHR) WITH ADDITIONAL OFFICE (KRA) SINCE 2007.
OUR FACILITIES ARE FULLY ACCREDITED BY ACR/FAD/IAC USING DIGITAL TECHNOLOGY AND BOARD CERIFED BRADIOLOGISTS.
~WEN Y. WANG, M.D., D.A.B.R .~ MERITA A. BANIA, M.D., D.A.B.R ~ASPAN S. OHSON, M.D., D.A.B.R.~ HAROLD R. TANENBAUM, M.D., D.A.B.R.~

DATE: _____

PATIENT
NAME: _____

PATIENT'S SOCIAL SECURITY #: _____
(If minor, give parents)
SEX: ☐ MALE ☐ FEMALE DATE OF BIRTH: _____

STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW ☐ WIDOWER

ADDRESS: _____APT #:_____
Street

_____
City State Zip

TELEPHONE
NUMBER: _____

OCCUPATION: (If minor, give parents) _____

EMPLOYER: _____

Business Address: _____

Telephone No.: _____

PRIMARY INSURANCE: _____ POLICY #: _____

SUBSCRIBER'S NAME: _____DATE OF BIRTH: _____

SECONDARY INSURANCE: _____ POLICY#: _____

SUBSCRIBER'S NAME: _____DATE OF BIRTH: _____

I, the undersigned certify that I (or my dependent) have insurance coverage with (name of insurance company):_____
And assign directly to Dr. Wang/Richmond Hill Radiology, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date