

Practice	Patient Num	* PATIENT REGISTRATION FORM* Read Thoroughly, Complete All Blanks & Please print Neatly	New <hr/> Update
----------	-------------	--------------------------------------------------------------------------------------------------------------	---------------------

Patient Name _____			
Address _____		_____	
LAST NAME		FIRST NAME	
CITY _____		ST _____ ZIP _____	
Phone [Home]() - _____		[other] () - _____ Martial Status.. Single / Married / Other	
Social Security No. - - _____		Date of Birth / / _____ Age _____ Sex.. Male / Female	
Employment Status. Employed / FT / PT Student / None at _____			
Co-pay (if any) \$ _____		Email _____ Ref.Physician _____	
Diagnosis _____		Allergies to _____	
Responsible Party _____		Phone () - _____	
Emergency Contact _____		Phone () - _____	

PRIMARY INSURANCE CARRIER

Ins. # _____		Insurance Co. Name _____	
ID No. _____		Grp.No. _____ Emp. _____	
Insured Name _____		Pt. Relation self / spouse / Child / other	
LAST NAME		FIRST NAME	
Address _____		Date of Birth / / _____ Sex. Male / Female	
City _____		St. _____ zip _____ Phone () - _____	

*** billed at the Practice direction only * SECONDARY INSURANCE CARRIER * not billed for an office visit co pay bal***

Ins. # _____		Insurance Co. Name _____	
ID No. _____		Grp.No. _____ Emp. _____	
Insured Name _____		Pt. Relation self / spouse / Child / other	
LAST NAME		FIRST NAME	
Address _____		Date of Birth / / _____ Sex. Male / Female	
City _____		St. _____ zip _____ Phone () - _____	

**** If a Medicare Plan is Secondary Payor Please Give Reason Here ** REQUIRED****

Consent for Treatment I as the patient or legal guardian of authorize the insurance carrier to make checks for medical expenses due to me payable to the attending staff or associated practice. I also authorize the release of any information regarding treatment to the Insurance Carrier. I further understand that I am Responsible for all medical expenses and agree to pay any expenses not covered by the above Insurance Carriers. I understand that after my primary carrier has paid or rejected payment, I am Responsible for the remaining balance and that billing my insurance is done of contractual obligation For participating carriers and is done only as a courtesy for other non-participating carriers.

Payment Terms Noted

- This practice accepts for UCR fee of participating carriers. In the event of two carriers the higher of the UCR will be Considered
- Delinquent accounts may be referred for third party collection and may be charged for associated collection and attorney/legal fees.

PLEASE PRESENT INSURANCE CARD WITH THIS FORM

X _____
Signature

_____/_____/_____
Date

To Update the above information, view your account and make payments online.

Visit www.ncdsinc.com and click on "Patient Login"