Practice	Patient #	* PATIENT REGISTRATION FORM *	New / Update
		Read Thoroughly, Complete ALL Blanks & Please Print Neatly	

PATIENT NAME _____ _____
LAST NAME *FIRST NAME, MI.*

Address _____ _____ ____ _____
STREET *CITY* *ST.* *ZIP*

Phone _____ _____ Martial Status ... ***Single*** / ***Married*** / ***Other***
Area Code *HOME* Area Code *WORK*

Social Security No. ___ - ___ - ____ Date of Birth ___/___/___ Age _____ Sex ... ***Male*** / ***Female***

Employment Status... ***Employed*** / ***FT Student*** / ***PT Student*** / ***None*** ... at _____
EMPLOYER / SCHOOL NAME (If Any)

Co-Pay (If Any) $ _____ Responsible Party _____ Phone _____
Area Code *HOME / WORK*

Ref. Phys. _____ Emergency Contact _____ Phone _____
Area Code *HOME / WORK*

PRIMARY INSURANCE CARRIER

Ins. # _____ Insurance Co. Name _____
NCDS - Only

ID No. _____ Grp. No. _____ Emp. _____

Insured Name _____ _____ Pt. Relation ***Self*** / ***Spouse*** / ***Child*** / ***Other***
LAST NAME *FIRST NAME, MI.*

Address _____ Date of Birth ___/___/___ Sex ..... ***Male*** / ***Female***
STREET ADDRESS

City _____ St. _____ Zip _____ Phone _____
Area Code *HOME*

SECONDARY INSURANCE CARRIER

**** billed at the practice's discresion only ****

**** not billed for an office visit copay balance ****

Ins. # _____ Insurance Co. Name _____
NCDS - Only

ID No. _____ Grp. No. _____ Emp. _____

Insured Name _____ _____ Pt. Relation ***Self*** / ***Spouse*** / ***Child*** / ***Other***
LAST NAME *FIRST NAME, MI.*

Address _____ Date of Birth ___/___/___ Sex ..... ***Male*** / ***Female***
STREET ADDRESS

City _____ St. _____ Zip _____ Phone _____
Area Code *HOME*

Consent for Treatment

I as the patient or legal guardian of, authorize the **Insurance Carrier** to make checks for medical expenses due 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 the UCR fee of participating carriers. In the event of two carriers the higher of the UCR fees will be considered.**
- **Delinquent accounts may be referred for third party collection and may be charged for associated collection and attorney/legal fees.**

X _____ ___/___/___
Signature *Date*

PLEASE PRESENT INSURANCE CARD WITH THIS FORM

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

to update the above information, view your account and make payments online.