

- One Webster Avenue, Suite 301
Poughkeepsie, NY 12601
845-483-5858 • Fax 845-483-5885
- 400 Westage Bus. Ctr., Suite 210
Fishkill, NY 12524
845-838-8480 • Fax 845-838-8474



For Office Use Only:

Patient Account # _____ Chart # _____
--

PATIENT INFORMATION

PLEASE PRINT

Today's Date: _____

Primary Care Physician: _____ Birth Date: ____/____/____

Name: _____ Gender: Male _____ Female _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (Apt #)

(City) (State) (Zip)

Social Security #: _____ Responsible Party: _____

Home Telephone #: (____) _____ - _____ Work #: (____) _____ - _____ Ext: _____

Cell Phone #: (____) _____ - _____ Alternate Phone #: (____) _____ - _____

Marital Status: Single Married Divorced Widow/Widower Lifetime Partner Spouse's/Partner's Name: _____
(Please Circle One)

Employer Name: _____

Employer Address: _____
(Street) (City) (State) (Zip)

In Case of Emergency Contact: _____ Telephone #: (____) _____ - _____

Relationship to Contact: _____

Insurance Information

Do you have Medical Insurance? Yes No **If Yes please complete the following:**

Primary Insurance Company: _____
(Name)

Insurance Company Address: _____
(Street) (City) (State) (Zip)

Identification Number: _____ Group Number: _____

** (If "Subscriber" of Insurance Coverage is other than patient, the below Information is Needed to Process Your Claim)*

*Subscriber Name: _____ *Relationship: _____

*Subscriber's Social Security #: _____ *Subscriber's Date of Birth: _____

*Subscriber's Employer: _____

*Subscriber's Employer's Address: _____
(Street) (City) (State) (Zip)

Secondary Insurance Company: _____
(Name)

Secondary Insurance Company Address: _____
(Street) (City) (State) (Zip)

Identification Number: _____ Group Number: _____

*Subscriber Name: _____ *Relationship: _____

*Subscriber's Social Security #: _____ *Subscriber's Date of Birth: _____

*Subscriber's Employer: _____
(Name)

*Subscriber's Employer's Address: _____
(Street) (City) (State) (Zip)

Attention: Medicare requires you to inform us if patient or spouse is employed and covered by employer's health plan. Are you or your spouse employed and covered by the employer's health plan? Yes No

Who referred you to our office? Family Friend Yellow Pages Insurance Company Other: _____

AUTHORIZATION

I hereby authorize New Century Medical Associates (NCMA), or its representatives to disclose to my Insurance Company(ies), upon request, any and all information for any illness or injury, medical history, consultation, prescriptions, or treatment. I hereby "assign" or authorize direct payment to NCMA toward any medical procedures performed, and authorize NCMA to file insurance claims on my behalf. I agree that this authorization shall be valid until rescinded in writing or replaced by one at a later date. A Photostatic copy of this authorization shall be considered as effective and valid as the original.

AGREEMENT TO PAY

In the event that my medical insurance does not pay for services rendered to me by New Century Medical Associates, or if a valid referral is not generated by my Primary Care Physician for services rendered, I agree to pay the usual and customary fees for these services. Also in the event if my account should be referred to a collection agency an additional 12% late fee will be added.

Patient/Guardian Signature: _____ **Date:** _____

Relationship: _____