REGISTRATION UPDATE FORM

PLEASE PRINT **TODAY'S DATE** _____

Name: _____
(First) (Middle Initial) (Last)

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

DOB: _____ **Home Phone:** (_____) _____ **Cell Phone:** (_____) _____

Email: _____

Primary Medical Insurance: _____
(Name) (Policy Number) (Group Number)

Policy Holder's Name: _____ **SSN:** _____ **DOB:** _____

Secondary Medical Insurance: _____
(Name) (Policy Number) (Group Number)

Policy Holder's Name: _____ **SSN:** _____ **DOB:** _____

In Case of Emergency, Please Notify: _____
(Name) (Relationship)

Cell Phone: (_____)_____ **Second Phone:** (_____)_____

I understand that my physician may release any medical record information of mine or my dependent to evaluate, treat and submit claims to my insurance company. I understand and agree that payment of medical benefits due to me be paid directly to Texas Oculoplastic Consultants. I understand that I am responsible for payment of all services rendered on my behalf or my dependent not covered by my insurance. I agree that payment is due at the time of service unless other arrangements have been made and agreed upon. If payment is not received by agreed dates, Texas Oculoplastic Consultants may accrue late charges of 1 to 1.5% (18% APR) to my account. If required, I also understand that a check of my credit history may be made. This consent will remain in effect until revoked by me in writing.

PAYMENT IS EXPECTED AT THE TIME THAT OFFICE SERVICES ARE RENDERED. THANK YOU.

Signature: _____ **Date:** _____