

REGISTRATION FORM

TODAY'S DATE _____

PLEASE PRINT

NAME: _____
 (FIRST) (MIDDLE INITIAL) (LAST)

ADDRESS: _____
 (STREET) (CITY) (STATE) (ZIP CODE)

HOME PHONE: () _____ **CELL:** () _____ **CHECK:** SINGLE ___ MARRIED ___ WIDOWED ___

BIRTHDATE: _____ **AGE:** _____ **SEX:** _____ **SOCIAL SECURITY NUMBER:** _____

OCCUPATION: _____ **OFFICE PHONE:** _____

EMPLOYER: _____ **ADDRESS:** _____

NAME OF SPOUSE/PARENT OF GUARDIAN: _____ **RELATIONSHIP** _____

ADDRESS: _____ **RESIDENCE PHONE:** _____

EMPLOYER: _____ **BUSINESS PHONE:** _____

REFERRED BY: _____ **PRIMARY CARE DOCTOR:** _____

ETHNIC BACKGROUND: HISPANIC ___ NOT HISPANIC ___

RACE: AMER. INDIAN/ESKIMO/ALEUT ___ ASIAN/PACIFIC ISLANDER ___ BLACK ___ CAUCASIAN ___ OTHER ___

IF A PATIENT REFERRED YOU, MAY WE THANK THEM? _____

PRIMARY MEDICAL INSURANCE: _____
 (NAME) (POLICY NUMBER) (GROUP)

POLICY HOLDER NAME: _____ **SS#:** _____ **DOB:** _____

SECONDARY MEDICAL INSURANCE: _____
 (NAME) (POLICY NUMBER) (GROUP)

POLICY HOLDER NAME: _____ **SS#:** _____ **DOB:** _____

IN CASE OF EMERGENCY, PLEASE NOTIFY: _____
 (NAME) (RELATIONSHIP)

WORK PHONE: _____ **HOME 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 1-1.5% (18% APR) to my account. If required, I also understand 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 _____

I acknowledge that the Notice of Privacy Practices has been made available to me in the lobby of TOC.

SIGNATURE _____