PEDIATRIC EYE CARE & SURGERY
Sarah J. Whang, M.D.

PATIENT REGISTRATION UPDATE SHEET

Child's Name____________________________Date of Birth______________Sex____

Person Responsible for the Account

Name____________________________________Relationship to Child_____________
Home Address______________________________________City__________________
State______________Zip__________________Tel (____)_______________________

Insurance Information

Primary

Name of Insured___________________________Date of Birth_____________Sex____
Relationship to Child________________
Name of Insurance Co____
ID/Certificate #____
Group/Plan #____
Referring Doctor (if different from PCP)_____________________________________
Primary Care Physician (PCP)____
Medical Group Name (if HMO)____

Secondary

Name of Insured___________________________Date of Birth_____________Sex____
Relationship to Child________________
Name of Insurance Co____
ID/Certificate #____
Group #____
Medical Group Name (if HMO)____

INSURANCE ELIGIBILITY GUARANTEE: I understand that if the above health insurance information provided by myself is not true or if I am not eligible under the terms of the Medical Subscriber Agreement, I am responsible for any and all charges for services rendered. If I do not have health insurance coverage, I agree to pay in full for all services rendered within 30 days of receiving a bill from this office.

____

Signature of Responsible Person   Relationship to Child   Date