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Acct. # _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial _____

Address : _____ City: _____

State: _____ Zip Code: _____ Home Phone: (____) _____ - _____ Work Phone:(____) _____ - _____

Social Security# _____ - _____ - _____ Male/Female _____ Date of Birth _____ - _____ - _____

Marital Status _____ Occupation _____

Name Of Employer _____

Employer's Address _____

In Case of an emergency, Contact Person & Phone #: _____

E-mail _____ Referred By: _____

MEDICAL INSURANCE INFORMATION

Primary Insurance: _____

Subscriber's Name: _____ Relationship to Subscriber: _____

Subscriber's I.D.#: _____

Secondary Insurance: _____

Subscriber's Name: _____ Relationship to Subscriber: _____

Subscriber's I.D.# _____

VISION INSURANCE

() Vision Service Plan () Medical Eye Services () Superior Vision Plan () AVP Vision () Eye Care Plan of America
() Other: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I, the undersigned, being the patient/legal guardian/person having legal custody/or person otherwise having legal authorization to consent. I freely give my consent to Dr. Jerold E. Beeve, Dr. Scott W. Beeve, & Associates, to examine and treat the patient registered above. I authorize my records to be released that may be requested for the purpose of paying for services rendered, and authorize the payment from any such medical benefits be made to our practice. I understand that dilating drops may be used in my examination and may blur my vision, making it unsafe to drive. I will not attempt to drive until I feel certain the effect of the medication has worn off. The effect may last an hour or longer.

Signature of Patient/Legal Guardian

Date