Beacon Family Eye Care Registration:

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate/Age	SS#
Address			Home#: Work#: Cell#:		How did you hear about us?	
Address 2			Email			
City	State	Zip	Employer Name & Address			Occupation
Emergency Contact		Phone#	Pharmacy			Pharmacy Phone
Family Physician/Address/Phone #				Referring Physician		

Medical Insurance

Name & Address	Policy Holder	Relationship	Copay	Policy ID#
1				
2				
3				

Guarantor (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate/Age	SS#
Address			Home#: Work#: Cell#:		How did you hear about us?	
Address 2			Email			
City	State	Zip	Employer Name & Address			Occupation
2 Last Name	First Name	Middle	Gender	Marital Status	Birthdate/Age	SS#
Address			Home#: Work#: Cell#:		How did you hear about us?	
Address 2			Email			
City	State	Zip	Employer Name & Address			Occupation

Hippa Approved Contacts

1 Last Name	First Name	Middle	Gender	Birthdate	SS#	Relationship
Address		City	State	Zip Code	Phone#	
2 Last Name	First Name	Middle	Gender	Birthdate	SS#	Relationship
Address		City	State	Zip Code	Phone#	

Patient's or Authorized Person's Signature

Signature **X**	Signature Date