

ALLEN L. BEEDE, O.D.
LISA Y. SHIROISHI, O.D.
 240 Meridian Avenue #3
 San Jose, CA 95126



PATIENT INFORMATION

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss		Last Name		First		Middle	
<input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/>							
Address				City		State	ZIP
Birth Date		Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	Home Phone () ()		Cell: () () Work () ()
Social Security No.			Drivers License No.				
Occupation			Employer or School			<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Other	
How did you hear about us? Friend or Family: _____ Insurance List / Yelp / Internet Search / Yellow pages / Other _____						e-mail address: _____	

ACCOUNT INFORMATION

Name of Individual Responsible for Account: <input type="checkbox"/> Self		Relationship to Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Name of Parent(s) or Legal Guardian (for patients under 18 years old)		Name of Conservator or Caretaker, if applicable.	
Address, if different from above:			Phone:

VISION INSURANCE

VISION Insurance Company	Name of <u>PRIMARY</u> SUBSCRIBER:	Relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:
Insurance ID No.	Subscriber's Social Security No:	Subscriber's Birth date:

SECONDARY VISION INSURANCE (if applicable)

2 nd VISION Insurance Company	Name of <u>PRIMARY</u> SUBSCRIBER	Relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:
Insurance ID No.	Subscriber's Social Security No:	Subscriber's Birth date:

MEDICAL INSURANCE

MEDICAL Health Insurance Company	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Other	Name of <u>PRIMARY</u> SUBSCRIBER	Relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:
Insurance ID / Policy No.	Subscriber's Social Security No:	Subscriber's Birth date:	

SECONDARY MEDICAL INSURANCE (if applicable)

2 nd MEDICAL Health Insurance Co.	<input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Other	Name of <u>PRIMARY</u> SUBSCRIBER	Relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:
Insurance ID / Policy No.	Subscriber's Social Security No:	Subscriber's Birth date:	

I authorize this provider's office to bill my vision and/or medical insurance for services rendered. I understand that I am responsible for any insurance co-payments and unpaid portions that the insurance denies or does not cover. Insurance is not a guarantee of payment and it is the patient responsibility to contact the insurance company to ensure coverage and benefits. Payment is due at the time services are rendered or upon delivery of devices. Our office cannot be held liable for breakage of frames which may occur during adjustment, repair, or during lens fabrication at the laboratory, as well as any lost or damaged frames during transportation to and from the laboratory unless it is a new warranted framed purchased at this office.

SIGNATURE: X	DATE
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Relationship to patient (if patient is a minor or patient is unable to sign)

SEE BACK ➔