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

PATIENT INFORMATION						
☐ Mr. ☐Ms. ☐Dr. ☐ Mrs. ☐Miss	**Last Name**		**First**			Middle
Address		City		State		Zip
Birth Date	Age	☐ Male ☐ Female	☐ Single ☐ Married ☐ Other	Home Phone ( )		Cell ( ) Work ( )
Social Security No.			Drivers License No.			
Occupation			Employer or School		☐ Full Time ☐Part Time ☐ Retired ☐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: ☐Self	Relationship to Patient: ☐Spouse ☐Parent ☐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 *PRIMARY* SUBSCRIBER:**	Relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other
Insurance ID No.	Subscriber's Social Security No.	**Subscriber's Birth date:**
SECONDARY VISION INSURACE (if applicable)		
2nd VISION Insurance Company	Name of ***PRIMARY*** SUBSCRIBER:	Relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other
Insurance ID No.	Subscriber's Social Security No.	**Subscriber's Birth date:**

MEDICAL INSURANCE			
Medical Health Insurance Company	**☐PPO** **☐HMO** **☐Other**	**Name of *PRIMARY* SUBSCRIBER:**	Relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other
Insurance ID / Policy No.	Subscriber's Social Security No.		Subscriber's Birth date:
SECONDARY MEDICAL INSURANCE (if applicable)			
2nd Medical Health Insurance Co.	**☐PPO** **☐HMO** **☐Other**	Name of ***PRIMARY*** SUBSCRIBER:	**Relationship to subscriber:** ☐Self ☐Spouse ☐Child ☐Other
Insurance ID / Policy No.	Subscriber's Social Security No.		Subscriber's Birth date:

I Authorize this provider's office to bill my vision insurance 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's responsibility to contact the insurance company the ensure coverage and benefits. Payment is due at the time of 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 the laboratory unless it is a new warranted frame purchased at this office.

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

SEE BACK ➥