



Jerold E. Beeve, M.D. & Scott W. Beeve, M.D.

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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 #: \_\_\_\_\_

Referred By: \_\_\_\_\_ E-mail \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

Primary Insurance: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship to Subscriber \_\_\_\_\_

Subscriber's I.D.#: \_\_\_\_\_ Subscriber's Grp #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Relationship to Subscriber \_\_\_\_\_

Subscriber's I.D.#: \_\_\_\_\_ Subscriber's Grp #: \_\_\_\_\_

**VISION INSURANCE**

Vision Plan  Medical Eye Services  Eye Care Plan Of America  Superior Vision Plan  
 Eye Med  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