BOSTON FOUNDATION FOR SIGHT
PATIENT REGISTRATION

(Please Print Clearly)

Patient's Name: _____, _____ **DOB:** _____/_____/_____
Last Name **First Name/MI** **MM** **DD** **YYYY**

Email: _____@_____._____
By providing your email address in the space above you are authorizing Boston Foundation for Sight to contact you electronically to receive periodic updates, patient care information and other patient communication. These updates will NOT be sent out via regular mail. Your e-mail address will be kept private and will not be shared with any third party. You may unsubscribe at any time.

Social Security #: _____-_____-_____ Sex: M F Marital Status: Sin Mar Div Sep Wid

Street Address: _____

City, State & Zip: _____Country: _____

Home phone #: (_____) _____-_____ Cell phone #: (_____) _____-_____
Work phone #: (_____) _____-_____ Other Phone#: (_____) _____-_____

Race (optional): Amer. Indian/AlaskanNative Asian Black/AfricanAmerican White/Caucasian
Hispanic/Latino/SpanishOrigin Native Hawaiian/Pacific Islander Other_____

Ethnicity (optional): Hispanic or Latino Non-Hispanic or Latino

Preferred Language: _____

Primary Care Physician: _____ Phone: (_____) _____-_____

City: _____ State: _____ Zip: _____

EMERGENCY CONTACT (**REQUIRED**)

Primary Name: _____ Relationship: _____ Phone: (_____) _____-_____

Secondary Name: _____ Relationship: _____ Phone: (_____) _____-_____

HEALTH INSURANCE

Name of primary insurance carrier: _____ Subscriber Name: _____

Relationship to Patient: _____ DOB: _____/_____/_____

Person Responsible For Payment (If other that patient)

Name: _____ DOB: _____/_____/_____

Street Address: _____

City, State, Zip: _____ Country _____

Telephone #: (_____) _____-_____ Relationship to patient: _____

_____ _____/_____/_____
Patient's Signature **Date**

_____ **Relationship to patient:**_____
Name of Guardian

_____ _____/_____/_____
Signature of Guardian **Date**

Revised 05/28/2013