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/Alaskan Native ☐ Asian ☐ Black/African American ☐ White/Caucasian ☐
Hispanic/Latino/Spanish Origin ☐ 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**

Name of Guardian **Relationship to patient:**

Signature of Guardian **Date**