PATIENT REGISTRATION

Stephen P. Beals, MD, PC

Clinic: 124 W Thomas Rd, 3rd Floor, Phoenix AZ 85013 | Mailing: 5410 N Scottsdale Rd, Ste E-400, Paradise Valley AZ 85253

Please Fill Out Completely and Print Clearly

Today's Date: ____________
Appt. Date: ______________

Patient Name ____________________
Birthdate ____________ Age ________ Sex: Female ______ Male _______ SSN: ______________
Patient Address Street ______________________ Apt # ______________
City ______________________ State __________ Zip ________-_____
Home Phone ______________ Mobile ______________ Work Phone______________
Best # to reach you: ______________ Email ______________ May we email you? ☐Yes ☐No

Employer ______________________ Occupation ______________
Marital Status ______________ Spouse Name ______________________

If Patient Is a Minor

Responsible Party ______________________

Mother's Name ______________	Father's Name ______________
Address (if different from above) ______________ ______________	Address (if different from above) ______________ ______________
Home Phone ______________	Home Phone ______________
Work Phone ______________	Work Phone ______________
Mobile Phone ______________	Mobile Phone ______________
SSN ______________	SSN ______________

List changes of patient's medical history during the past year: ______________________
____

Primary Care Physician: ______________________ Phone ______________
Address ______________________City ______________St _____ Zip __________

PATIENT INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
Insurance Co. Name ______________	Insurance Co. Name ______________
Insurance Co. Address ______________ ______________	Insurance Co. Address ______________ ______________
Policy Holder's Name ______________	Policy Holder's Name ______________
Relationship to Patient: ☐ self ☐ spouse ☐ parent ☐ other______	Relationship to Patient: ☐ self ☐ spouse ☐ parent ☐ other_______
Employer ______________	Employer ______________
Policy # ______________	Policy # ______________
Group # ______________	Group # ______________
Policy Holder's SSN ______________	Policy Holder's SSN ______________
Policy Holder's DOB __________ Sex: ☐ M ☐ F	Policy Holder's DOB __________ Sex: ☐ M ☐ F

****ALL PATIENTS OR RESPONSIBLE PARTIES MUST SIGN BELOW REGARDLESS OF INSURANCE STATUS OR SELF PAY SITUATIONS**

I hereby authorize pre and post operative photographs to be taken of me for medical records and insurance claim purposes. I agree that this office may release medical records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan.

I hereby assign all major medical and/or surgical insurance benefits to which I am entitled, including private insurance, Medicare and any other health plan or insurance benefits, to the provider indicated above. I understand that I am financially responsible for all charges whether or not paid by said insurance, unless assignee has executed an agreement with my insurance provider or plan. I understand that if such an agreement has been executed, I am responsible to pay any deductible and/or co-payment required under the terms of my insurance plan. Should collection procedures become necessary, I agree to pay the collection agency's cost and/or reasonable attorney's fees.

A photocopy of this assignment/authorization is to be considered as valid as the original.

______________________________ ______________________

Signature of Patient or Responsible Party **Date**

Stephen P. Beals, MD, PC

I have received and understand the
HIPAA Notice of Privacy Practices

Signature ________________________________
Print Name ______________________________
Patient Name (if minor) __________________
Date ____________________________________

I authorize the following persons to pick up medical records or receive private medical information pertaining to my/my child's health care:

Name ______________________ relationship __________
Name ______________________ relationship __________
Name ______________________ relationship __________

Sign ________________________ Date ____________