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

☐ New Patient
☐ Update_____
(Date)

Today's Date _____ Appointment Date _____
Patient Name _____
Birthdate _____ Age _____ Sex: Female _____ Male _____
Social Security Number _____

Patient Address Street_____
Apt # _____
City _____ State _____ Zip _____-_____
Home Phone _____ Work Phone_____
Mobile _____ Email _____
Best # to reach you? _____ May we contact you...by Email? _____@ home? _____ @ work? _____
May we leave a voicemail message for you? _____ Primary Language Spoken? _____

Employer _____ Occupation _____
Marital Status _____ Spouse Name _____
Nearest Relative _____
Name/Relationship Phone Number

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 _____

Reason For Visit _____
How Did You Hear About Us? _____
If This Is An Injury, Was It: Auto Accident _____ Job-related _____ Other _____
Date of Injury _____

Primary Care Physician	**Referring Physician**
Name _____	Name _____
Address _____	Address _____
City _____ St _____ Zip _____	City _____ St _____ Zip _____
Phone _____	Phone _____
Specialty _____	Specialty _____

Other Physicians / Doctors	**Specialty**	**Phone**
_____		
_____		

PATIENT INSURANCE INFORMATION

Stephen P. Beals, MD, PC

Please Fill Out Completely and Print Clearly

Patient Name _____ Date _____

Primary Insurance

Insurance Co. Name _____
Insurance Co. Address _____
_____
Policy Holder's Name _____
Relationship to Patient ☐ self ☐ spouse ☐ parent ☐ other_____
Employer _____
Policy # _____
Group # _____
Policy Holder's SSN _____
Policy Holder's Birth date _____ Sex ☐ M ☐ F

I confirm the above patient named has no other insurance coverage

_____ _____
Signature of Patient/Responsible Party Date

Secondary Insurance

Insurance Co. Name _____
Insurance Co. Address _____
_____
Policy Holder's Name _____
Relationship to Patient ☐ self ☐ spouse ☐ child ☐ other_____
Employer _____
Policy # _____
Group # _____
Policy Holder's SSN _____
Policy Holder's Birth date _____ 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 _____

PATIENT MEDICAL HISTORY

Stephen P. Beals, MD, PC

Please Fill Out Completely and Print Clearly

Date _____ Date of Birth: _____

Last Name _____ First _____ MI _____

Age _____ Ht. _____ Wt. _____ Sex: _____ Marital Status: _____ Date of last physical exam _____

Please list any known drug allergies: _____

Please indicate if you have or have had any of the following (if yes, give date of occurrence):

Yes	No		When?	Yes	No		When?	Yes	No		When?
☐	☐	Stroke		☐	☐	Migraine		☐	☐	Rheumatic heart disease	
☐	☐	Cancer		☐	☐	Hay Fever		☐	☐	Bleeding tendency	
☐	☐	TB		☐	☐	Colitis		☐	☐	High blood pressure	
☐	☐	Leukemia		☐	☐	Goiter		☐	☐	Congenital heart disease	
☐	☐	Bronchitis		☐	☐	Bladder Infection		☐	☐	Nervous breakdown	
☐	☐	Epilepsy		☐	☐	Asthma		☐	☐	Arthritis	
☐	☐	Pneumonia		☐	☐	Heart Attack		☐	☐	Tonsillitis	
☐	☐	Diabetes		☐	☐	Stomach Ulcers		☐	☐	HIV	
☐	☐	Hepatitis		☐	☐	Kidney Disease		☐	☐	Other	

List any other serious illnesses you have had, plus date:

_____

_____

Do you know of any blood relative who has or had any of the above conditions? If yes, please state condition and relationship:_____

_____

List and give dates of previous surgeries: _____

_____

_____

Have you ever had a complication related to anesthesia? ☐ No ☐ Yes, describe: _____

_____

Yes	No	
☐	☐	Do you smoke?
		How much? _____
		How long? _____
☐	☐	Do you drink more than 6 cups of coffee a day?
		How much? _____
		How long? _____
☐	☐	Do you regularly drink alcohol or beer?
		How much? _____
☐	☐	Do you frequently have bleeding gums?
☐	☐	Do you bleed excessively from tooth extractions?
☐	☐	Do you have nose bleeds?

Yes	No	**Do you regularly take**:
☐	☐	Aspirin
☐	☐	Bufferin
☐	☐	Anacin
☐	☐	Motrin
☐	☐	Other anti-inflammatory drugs
☐	☐	Have you ever had a drug addiction?

List all herbal supplements and vitamins you take:_____

_____

_____

Check any of the following medication you are now taking (and provide name):

☐	Cortisone _____	☐	Blood Pressure pills _____	☐	Sleeping pills _____
☐	Digitalis _____	☐	Cough Medicine _____	☐	headache pills _____
☐	Hormones _____	☐	Insulin or diabetes pills _____	☐	Blood thinning pills _____
☐	Laxatives _____	☐	Thyroid medicine _____	☐	Medication for arthritis _____
☐	Tranquilizers_____	☐	Weight reduction pills_____	☐	Phenobarbital _____
☐	Dilantin _____	☐	Birth control pills _____	☐	Antiobiotics _____
☐	Barbituates _____	☐	Water pills _____	☐	Other _____
☐	Shots _____	☐	Iron or poor blood pills _____		_____