Welcome to Dr. Beam's Office….

Thank you for selecting us for your plastic surgery needs. We will strive to provide you with the best possible care. Please fill out this form completely. If you have any questions, please ask us – we will be happy to help.

PATIENT'S PERSONAL INFORMATION

Today's Date: _____

PATIENT'S NAME: _____

DATE OF BIRTH _____ AGE _____

STREET ADDRESS: _____

HOME PHONE : _____

CELL PHONE: _____

CITY, STATE _____ZIP _____

WORK PHONE: _____x _____

EMPLOYER: _____

OCCUPATION: _____

EMERGENCY CONTACT:_____

WHOM MAY WE THANK FOR REFERRING YOU?

RELATIONSHIP: _____

MARITAL STATUS: SINGLE MARRIED SEPARATED

TELEPHONE NUMBER: _____

DIVORCED WIDOWED

COSMETIC PATIENTS: RESPONSIBLE PARTY/PAYMENT INFORMATION

Is the condition for which you seek care the result of any type of accident? **YES_____ NO_____**

NAME OF RESPONSIBLE PARTY: _____

RELATIONSHIP TO PATIENT: _____

STREET ADDRESS:_____

HOME PHONE: _____

CITY, STATE_____ ZIP:_____

CELL PHONE: _____

WORK PHONE: _____ x _____

INSURANCE/RESPONSIBLE PARTY INFORMATION

Is the condition for which you seek care the result of any type of accident? YES_____ NO_____

PRIMARY INSURANCE COMPANY AND PLAN NAME: _____

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S DATE OF BIRTH _____

CARD ID #: _____ GROUP #: _____

EMPLOYER: _____

EMPLOYER TELEPHONE NUMBER: _____

CO-PAY $_____ DEDUCTIBLE $_____ MET? Y N

CO-INS %_____ REFERRAL REQUIRED? _____

SECONDARY INSURANCE COMPANY AND PLAN NAME: _____

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S DATE OF BIRTH _____

CARD ID #: _____ GROUP #: _____

EMPLOYER: _____

EMPLOYER TELEPHONE NUMBER: _____

CO-PAY $_____ DEDUCTIBLE $_____ MET? Y N

CO-INS %_____ REFERRAL REQUIRED? _____

I HEREBY AUTHORIZE TREATMENT OF THE ABOVE PATIENT AND BILLING TO THE INSURANCE COMPANY(S) LISTED. I UNDERSTAND AND AGREE THAT A HEALTH INSURANCE POLICY IS A CONTRACT BETWEEN THE INSURANCE CARRIER AND THE PATIENT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO HAVE ALL NECESSARY REFERRALS IN PLACE. I UNDERSTAND THAT IF A CLAIM IS DENIED BY MY INSURANCE COMPANY, I AM RESPONSIBLE FOR PAYMENT. I AUTHORIZE DR. BEAM TO RELEASE TO THE INSURANCE COMPANY(S) ANY INFORMATION REQUIRED TO PROCESS A CLAIM.

SIGNATURE: _____, _____ DATE: _____

RELATIONSHIP TO PATIENT