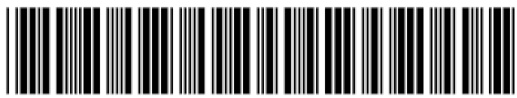

BEACHWOOD PLASTIC SURGERY & MEDICAL SPA
3609 PARK EAST DRIVE, SUITE 206
BEACHWOOD, OHIO 44122

PATIENT REGISTRATION

Patient Information

Full Name: ____________________ Date of Birth: ____________________

Social Security #: ____________________ Sex: ☐ Male ☐ Female

Contact Information

Home Address: ____________________ Apt: ________ Home phone: ____________________

City/State/Zip: ____________________ Cell phone: ____________________

Email: ____________________ Work phone: ____________________

Employer: ____________________ Occupation: ____________________

Emergency Contact

Name: ____________________ Contact Number: ____________________

Relation: ____________________

Can we leave a message? ☐ Home ☐ Work ☐ With Emergency Contact ☐ Send Email

Referral Information

How did you hear about our office? ____________________

Referring physician's name & address: ____________________

(If applicable) ____________________

Insurance Information (Please also provide a copy of your card)

Primary Insurance

Company: ____________________ Provider Phone #: ____________________

Policy Number: ____________________ Group Number: ____________________

Claim address: ____________________ City/State/Zip: ____________________

If policy subscriber is other than you we need their:

Name: ____________________ Date of Birth: ____________________

Secondary Insurance

Company: ____________________ Provider Phone #: ____________________

Policy Number: ____________________ Group Number: ____________________

Claim address: ____________________ City/State/Zip: ____________________

If policy subscriber is other than self we need their:

Name: ____________________ Date of Birth: ____________________

I, the undersigned, am aware that I am responsible for the payment of any co-pays and/or deductibles that may apply under my medical insurance contract. It is my responsibility to check with my insurance company to be sure that the physician is in my insurance network. I assume personal responsibility for any amount that insurance does not pay and deems payable by myself. I also agree to pay all fees if I have no insurance coverage or my insurance company denies coverage for any reason. It is my responsibility to have a referral, if necessary, at the time of service. I have received a copy of the Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice. I authorize the release of any medical information necessary to process my claims or receive pre-authorization, and payment of benefits directly to the office or doctor.

Signature: ____________________ Date: ____________________