Jon L. Hyman, MD, PC

PATIENT INFORMATION

NAME _____ AGE _____ DOB _____ M F
LAST FIRST MI

SOCIAL SECURITY NUMBER _____ MARRIED SINGLE SIGNIFICANT OTHER

ADDRESS _____ EMAIL _____

CITY, STATE & ZIP _____ HOME PHONE _____

BUSINESS PHONE _____ CELL PHONE _____

Whom may we thank for referring you to us? _____

EMPLOYER OR SCHOOL NAME _____

ADDRESS _____ WORK PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

HOME PHONE _____ BUSINESS / CELL PHONE_____

PRIMARY CARE PHYSICIAN _____ PHONE NUMBER _____

INSURANCE INFORMATION

IS THIS A WORK RELATED INJURY? YES NO DO YOU HAVE AN ATTORNEY? YES NO

ATTORNEY'S NAME _____ PHONE NUMBER _____

ARE YOU COVERED BY MEDICARE? YES NO

IF SO, WHICH DOCTOR REFERRED YOU HERE? _____ PHONE NUMBER _____

PRIMARY CARRIER _____	SECONDARY CARRIER _____
POLICY NUMBER _____	POLICY NUMBER _____
GROUP NUMBER _____	GROUP NUMBER _____
POLICY HOLDER _____	POLICY HOLDER _____
DOB OF POLICY HOLDER _____	DOB OF POLICY HOLDER _____
RELATIONSHIP TO PATIENT _____	RELATIONSHIP TO PATIENT _____

FINANCIAL RESPONSIBILITY

All co-payments, out-of-pockets, or coinsurance are due at the time of service. As a courtesy we will submit all of our professional charges to your insurance company. Anything that is not covered by insurance is the patient's responsibility.

I, _____, have read the above and understand that I am financially responsible for anything that is not paid by my insurance.

By signing below, I authorize Jon L. Hyman, MD, PC to furnish information to insurance carriers or other healthcare providers concerning my Present illness/injury and treatment.

Date: _____ Signature: _____

*Please ask one of our staff members if you have any questions concerning this form.