JOSHUA B. HYMAN, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY

PATIENT REGISTRATION

PATIENT'S NAME _____ AGE _____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ E-MAIL _____

SOCIAL SECURITY _____ DATE OF BIRTH _____

EMERGENCY CONTACT _____ PHONE _____

MEDICAL DOCTOR _____ PHONE _____

REFERRING DOCTOR _____ PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ I.D. _____

NAME OF INSURED (IF OTHER THAN PATIENT) _____

DATE OF BIRTH _____ SOCIAL SECURITY _____

I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in peer review meetings.

PATIENT SIGNATURE _____ **DATE** _____

Authorization: I hereby authorize JOSHUA B. HYMAN, M.D. to furnish the above information to insurance carriers concerning this illness/accident. Additionally, I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I acknowledge that the policy regarding insurance and billing has been made available to me and that I am will to comply with these parameters.

GUARANTOR / PATIENT SIGNATURE _____ **DATE** _____

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