

■ **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** \_\_\_\_\_